Registered at the G.P.O., Sydney, for Transmission by Post as a Newspaper. Published Weekly.

THE MEDICAL JOURNAL OF AUSTRALIA

(With which "The Australasian Medical Gazette," and "The Australian Medical Journal" are incorporated.)

The Journal of the Australian Branches of the British Medical Association.

VOL. II.—5TH YEAR.—NO. 7. SYDNEY: SATURDAY, AUGUST 17, 1918. PRICE 6D.

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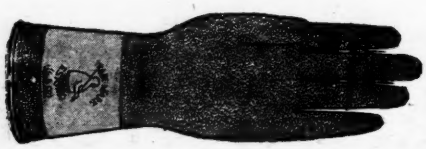
RUBBER  GLOVES

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. II.—5TH YEAR. SYDNEY: SATURDAY, AUGUST 17, 1918. No. 7.

"OUR FIRST PRESIDENT."[1]

By **Jos. C. Verco, M.D., Lond., F.R.C.S., Eng.,**
President, South Australian Branch of the British Medical Association.

Ladies and Gentlemen,—Allow me to thank you for the renewed honour of the presidency of our Branch. This honour is now-a-days no sinecure, and the work is far more arduous than it was thirty years ago. But the war still rages, and imposes its excessive demands upon the medical profession. So, though the duty may be strenuous, I am ready in my degree to lessen the labours of others who are still hard pressed.

Thirty-five years ago there passed away a medical practitioner, who has left with me the memory of a gentle and courteous old physician, Dr. William Gosse. It has occurred to me that a sketch of the life of the first President of our Branch would be an innovation in retiring addresses, which might have a charm in its novelty, and might furnish a light and agreeable morsel to follow the rather solid courses in the menu of our annual dinner, consisting of the resolutions for submission to the Federal Committee. May be some of you, more intimately acquainted with him than myself, possess information not now supplied. If so, it will be a pleasure to receive it, and, if desired, to add it to what is here recorded.

"He was born in Newfoundland, in the year 1813, being the son of Mr. Gosse, a member of the firm of Gosse, Pack and Fryer. While very young he left that island for England, where his father settled at Poole in Dorsetshire. He was educated at Mr. Buller's school, at Southampton, and afterwards commenced his professional studies in connexion with a Mr. Salter, of Poole." This was in the days when young men were apprenticed to medical practitioners, to serve with them for some years, before entering at a medical school. They thus picked up considerable practical information, and especially learned by experience their own deficiencies, so that when they began later their medical course at the school, and "walked the hospital" where alone these could be supplied, they knew what they lacked in theory and practice, and sought to make up their deficiencies in information and handicraft. "From Poole he went to London, and entered Guy's Hospital, as a pupil of Mr. Morgan, who was also his brother-in-law." In those days surgeons at the large London hospitals had their own pupils, who were attached to them, and paid them fees. The relationship between young Mr. Gosse and Mr. Morgan would explain in part why he entered at Guy's. But another reason may be suggested. In the first volume of Guy's Hospital Reports, published in 1836, appears the name of T. B. Salter, of Poole, a scholar at Guy's, who obtained his diploma of L.S.A., London, that year, the same year as did young Gosse. They were probably fellow apprentices of young Salter's father, and came up to Guy's as fellow students. Guy's at that time had several teachers who are accounted stars in the professional firmament. Bransby Cooper, Aston Key, John Hilton, all well known surgeons, and last but most brilliant of all, Sir Astley Cooper. And on the medical side were Golding Bird, Dr. Barlow, Dr. Hodgkins, of Hodgkins's disease, Dr. Bright, whose name has been given to diseases of the kidney, and Dr. Addison, the discoverer of the disease of the supra-renal body. The atmosphere at Guy's would surely tend to develope a healthy and active medical and surgical physique, and such teachers would leave their impress upon an intelligent and industrious student. Curiously enough, the year in which Wm. Gosse obtained his diplomas was that in which Guy's Hospital Reports were begun, Vol. 1 being issued in 1836, and they have been continued without intermission until the present time.

In 1836 he obtained the diplomas of Member of the Royal College of Surgeons, England, and Licentiate of the Society of Apothecaries, London, which in those days were the two common qualifications to practice. "Having finished his education he took up his residence at Hoddeston, in Hertfordshire, where he married Agnes, eldest daughter of Mr. Grant, of Old Broad Street, London." (Her maiden name was borne by one of the sons, well known at J. L. Young's school as Grant Gosse, and the eldest daughter was Agnes Grant Gosse, afterwards Mrs. Alexander Hay.) "In his early days he was associated with Philip H. Gosse, the naturalist, whom he assisted a great deal in collecting specimens, being much taken up with the subject of natural history." (I know of no evidence suggesting his pursuit of this department of science in South Australia.) He practised for fifteen years at Hoddeston, where all his children were born, and then, his health becoming impaired through bronchitis, he left for Australia, being advised to try a warmer climate. He landed in Melbourne in 1850, but only remained in that city a week or so, and arrived in Adelaide on the last day of that year. In 1851 he was infected by the gold fever, and went to the Victorian diggings, but being among those who were unsuccessful, he soon returned to South Australia.

On April the first, 1851, he was registered in this province (as our State was then styled), being No. 70 on the roll. This had been commenced in 1844 (the year in which our first Medical Act came into force). No. 1 on the register, December 28, 1844, was Mr. James George Nash, who had been Colonial Surgeon since 1839, and who was still holding the position when Dr. Gosse arrived in Adelaide.

In June of the following year, 1852, on the recommendation of the Medical Board, he was appointed, together with Dr. Baruh, to be Honorary Medical Officer of the Adelaide Hospital, in the room of Dr. Tidmarsh and Mr. Taylor, who had resigned; and they had as their House Surgeon Dr. Bompas, who was also Resident Medical Officer at the Lunatic Asylum (July 7, 1852, *Government Gazette*). In the Hospital

[1] Presidential Address delivered at the Annual Meeting of the South Australian Branch of the British Medical Association on June 27, 1918.

records his name can be traced as working in this honorary capacity until May, 1857.

About 1857 he entered into partnership with Dr. Bayer, a German, who was regarded as among the foremost surgeons, if not the leader of his time. For about nine years the firm of Gosse and Bayer was a household word, and was only dissolved by the death of the latter in 1866. Thereupon Dr. Gosse associated with himself Dr. Horatio T. Whittell, and this partnership endured until 1873, when his son, Dr. Charles Gosse, who had gone to England for his medical education, and had made a special study of ophthalmic surgery, returned and joined his father. Seven years later the latter gave up practice, retaining only the Chairmanship of the Central Board of Health, and spent the last three years of his life in comparative retirement.

In 1870 he paid a visit to England, for the benefit of his health, and returned considerably improved. As, however, he brought back with him the medical degree of M.D., Heidelberg, and the surgical diploma of F.R.C.S., England, he must have done some work during his holiday, and have had sufficient vim of body and mind to frame an ambitious project and attain it. There is a definite confirmatory incident in reference to this. On his return from Europe an announcement was made in the *Government Gazette* of a reappointment, and in the next issue appears this: "*Erratum.*—In notice of appointment in November, 1870, for Wm. Gosse, Esq., M.R.C.S., to be member of the Board of Management of Adelaide Hospital, read Wm. Gosse, Esq., M.D., F.R.C.S., London." He had for many years the leading practice in Adelaide, and was physician to the well-to-do, and the leaders in society, including the Governors of the province.

He was seventy years old when he died, quite a good age for a medical man who has been engaged all his days (and shall we say many of his nights) in a general practice. He is reported, though he retired at 67, to have succumbed to "senile decay rather than to any actual malady."

He was a man of spare habit, with strikingly light grey-blue eyes, rather bushy eyebrows, a large nose, wide mouth, with full lips, clean-shaven, but for a narrow line of grey side whiskers, and thin grey hair, almost white. My recollection is of a grey-headed man with a quiet, kindly face, and a pleasant smile, as happily preserved for us in our Album of Past Presidents. His hands were well knotted with tophi, from gout. He had a somewhat delicate appearance, which agreed with the ground given for his immigration to Australia in search of health in a warmer climate to cure his bronchitis, and with the alleged cause of his death from gradually increasing weakness apart from local disease.

During the 'sixties he lived in a house at the corner of Gawler Place and North Terrace, where later Mr. Gurner, the dentist, practised, and later still Mark J. Symons, when he began his work as an eye-specialist. It has now been demolished and replaced by Gawler Chambers. He removed afterwards further west along North Terrace to the building occupied on his decease by Dr. Charles Gosse, then by Dr. Sprod, and lastly by Dr. Marten, and now known as Gonville Chambers, where several of our leading medical men have their consulting rooms. When he retired from private practice he took up his residence at Kent Town, whence his remains were removed to the North Road Cemetery.

South Australian Medical Board.—In 1854 (December 14) he was given a seat on the South Australian Medical Board, *vice* Dr. Kent (resigned), and in 1857 (March 19), when Colonial Surgeon, he was gazetted *ex officio* President of the Medical Board, *vice* J. G. Nash (resigned). His seat he retained for the remainder of his life.

The Hospital Board.—Until 1867 (March 13) the Adelaide Hospital appears to have been under control of the Medical Board, which recommended both the honorary and paid staff for appointment by the Government. But in that year a General Committee for the Management of the Hospital was created, and the members of the Medical Board were all put upon that Committee, *viz.*, Moore, Wyatt, Duncan, Mayo, Gosse, Phillips, Bayer and Scott. Every year in the *Gazette* appears the announcement of his reappointment, upon what was from the following year styled the Board of Management of the Adelaide Hospital, until his decease.

The Lunatic Asylum.—In December, 1854, he was made a Visitor of the Adelaide Lunatic Asylum. About a year later (January 2, 1856) Acting Colonial Surgeon and Superintendent of Lunatics (from January 1) during absence on leave of Dr. Nash. Next year (March 10, 1857,) he was made Colonial Surgeon and Superintendent of the Lunatic Asylum, *vice* Dr. Nash (resigned). He could only have kept this office about a year, for in March, 1858, he was gazetted again a Visitor of the Public Lunatic Asylum, *vice* the Honourable F. S. Dutton (resigned), and thence onward he was periodically reappointed visitor until he died (1861, 1865, 1866, 1867, 1868, 1870, 1872, 1873, 1875, 1876, 1878, 1879, 1880, etc.).

Central Vaccine Board.—In 1854 a compulsory Vaccination Act was passed (No. 16 of 1853), which provided for a Central Vaccine Board of not less than three legally qualified medical practitioners, of whom the Colonial Surgeon for the time being shall be one, the members whereof shall be nominated and removable by the Governor. In December, 1854, Dr. Gosse was appointed a member of the Central Vaccine Board in place of Dr. Kent (resigned). Apparently the appointment was during pleasure, and we find in 1866 Dr. Gosse was reappointed in place of Dr. Woodforde (deceased). In 1872 this Act was repealed and the Board abolished and replaced by a Vaccination Officer, appointed by the Governor.

Central Board of Health.—By the Health Act (No. 22), 1873, Regulation 4 provided that the Governor should appoint a Central Board of Health, consisting of four to seven members, the Chairman to be called the President of the Central Board of Health. The Governor should appoint one of the members of this board to be its president, who should have a fixed salary, all other members receiving one guinea each for every meeting attended. In January, 1874, the *Gazette* announced Dr. Wm. Gosse as a member of the Board and also as its Chairman. This office he held for the rest of his life. In September, 1875, a Commission was appointed to inquire into and report

upon the general question of sanitation for the province, and he was appointed a member of it, doubtless as President of the Board of Health.

The Australian Mutual Provident Society was established in Adelaide in 1872, and directly a Board of Directors for South Australia was formed, Dr. Gosse was given a seat upon it, which he retained until his death.

The Home for Incurables.—Rumour has it that one day Mrs. G. H. Farr, the wife of Dr. Farr, headmaster of the Collegiate School of St. Peter, in company with Dr. Gosse, was dining at the Honourable Alex. Hay's, and suggested the establishment of a home for incurables. The idea appealed to the doctor, and he applied himself to actualize it, and in 1879 the home was founded, and Dr. Gosse was made chairman of its committee of management, a position filled by him to the last. The year after he died, a new wing of the building was named after him, and stands to-day as a memorial of his foresight and active benevolence.

The South Australian Institution for the Blind and Deaf and Dumb was initiated by Mr. William Townsend. Before it was opened for pupils in 1874, Dr. Gosse had promised Mr. Townsend to act as Honourary Medical Officer, and this promise he kept till the day of his death.

The Medical Benevolent Association of South Australia.—In very early days a South Australian Medical Association was established, of which he was a member. But in 1879 the South Australian Branch of the British Medical Association was formed. This grew apace in numbers, and rendered the continued existence of the earlier association unnecessary; so this was abolished in 1881, and its members very generously founded the South Australian Medical Benevolent Association, to which it transferred all its accumulated funds, and Dr. Gosse was appointed one of the life members of the Committee of Management of the new association.

Religion.—He belonged to the Anglican communion, and with Dr. Mayo and Dr. Phillips attended at Trinity Church, North Terrace, when Dean Farrell was incumbent. In 1866 he was a lay representative of Holy Trinity at the Diocesan Synod, and this was repeated year by year till 1880. He was a member of the Standing Committee of Synod for some years, and was a co-trustee of St. Luke's, Whitmore Square, from 1875 to 1883. He evidently took an active interest in religious affairs, and devoted some of his scanty leisure to the concerns of his church.

Politics.—In the early days, just after he came to the province, politics were very lively, in more senses than one. In the first place there was no vote by ballot, but elections took place by open voting. Every man had to go to the poll, and openly declare for whom he voted; all knew on which side he stood, and he was liable to abuse or assault from those who differed from him in politics. And in the second place several subjects of surpassing moment were under discussion for immediate and final settlement; two especially, representative government, and grants in aid of religious bodies. The majority of the people were determined to have political freedom, *i.e.*, full representation without any vice-regal nominees, and religious freedom with no patronage or interference from the political powers. The contests were earnest and without gloves (often actually so), sometimes with the backs and legs of broken chairs, taken from the Committee rooms of opposing candidates, and once (it is affirmed) with a big stone in the toe of a stocking taken from her leg, and swung round by the hand of a big burly Irish woman. It was difficult for any man with pronounced opinions (and who could fail to have them in such stirring times) not to reveal his partisanship, and so we find the name of Dr. Wm. Gosse in the newspaper (*Examiner*, April, 1853,) among the committee men, pledged to secure the return of James Hurtle Fisher, as Member of the Legislative Council for West Adelaide. It is very interesting to read some issues of the press in those early days, and to see what an active and public part several leading medical men took in the momentous struggles of their time.

In April, 1855 (April 26), he was gazetted a Justice of the Peace.

Education.—In 1852 an *Education Act* (No. 20, January 2, 1852) was passed, one of its provisions being a Central Board of Education, to be nominated by the Governor, by and with the advice of the Executive Council, the members of the said Board not to exceed seven in number, to be selected by the Executive Council, without reference to party politics, and indifferently from the different religious bodies, not being ministers of religion, and two of such board who have attended the least number of times to retire annually, although capable of reappointment. In May, 1853, the next year, his appointment was gazetted, and he was periodically reappointed (in 1854, 1860, 1861, 1864, 1867, 1868, 1870). In 1875 this *Act* was repealed (by *Act* II., 1875), and a Council of Education (with a salaried officer as President, appointed during pleasure), the other members holding office for two years and receiving each one guinea for every meeting attended. He would appear to have been among the first chosen under the old *Act*, and to have served continuously until it was abolished, that is for about twenty-two years.

The Institute.—In 1874 he became a governor of the South Australian Institute as a representative of the subscribers, and continued to act until his death. The year after this the Public Library, Museum and Art Gallery were put under a Board of Governors, and the South Australian Institute was merged into this.

The University of Adelaide.—This began its academical work in March, 1876; and the Senate elected in December, 1877, its first group of members of Council, and among them was Dr. Wm. Gosse, who was also chosen as the first Warden of the Senate, which office he retained for the rest of his days, but for an interval of two years, when Dr. Farr took his place.

The Royal Society of South Australia.—One phase of Dr. Gosse's life is probably known to but very few. To me it has been of pleasant interest, namely, his relation to what is known as the Royal Society of South Australia. In January, 1853, a preliminary meeting was held in the house of my old-time school master, Mr. J. L. Young, in Stephens Place, off North Terrace, at which Dr. Gosse was present to establish a scientific, literary and philosophical institution, to

be named the Adelaide Philosophical Society. Its founders were such men as Herschel Babbage, John Howard Clark, John L. Young. This Society has had an uninterrupted career until the present day, although in 1879, through the influence of Professor Tate, it was converted into the Royal Society of South Australia. Up to that time the Governor was always the President, since then he has been Patron. At the first Annual meeting in 1854, Dr. Gosse was elected Vice-President, and the same honour was conferred upon him later, with the further honour of Member of Council. The office was no sinecure, because the Governor was frequently unable to be present, and the Vice-President had to take the chair. Reports of proceedings show him to have been a very frequent attendant, to have entered freely into discussion of the various questions raised, and to have had allotted to him many special duties, such as investigation into supposed discoveries, arranging for affiliation with other bodies, the collection of information, etc. On two occasions he read papers before the Society. His first on Respiration was announced for July 11, 1854, but when the evening came he did not appear, having "been prevented from attending by a professional engagement." However, he read it at the next meeting. The newspaper report written, I doubt not, by Mr. John Howard Clark, is a literary treat, and a model for such reports, clear, concise, consecutive, complete, and displaying an intelligent treatment of the subject.

When Chairman of the Central Board of Health he read a second paper (April 20, 1875) before an audience of fifty persons, the Vice-President, Herschel Babbage, being in the chair, entitled "The Advantages and Desirability of Applying a System of Deep Drainage to the City of Adelaide." He pleaded for a complete system of underground drainage of all solid and liquid sewage by water carriage to the sea, and gave evidence from European authorities of the great reduction in urban death-rates, effected by such sewerage system. The subject was discussed by Rowland Rees, M.P., R. G. Thomas, Secretary to the Board of Health, G. H. Cossins, Dean Russell, Rupert Ingleby, C. Bonney, S.M., and B.H. Babbage, Chairman. Dr. Bleasdale, a member of the Central Board of Health in Melbourne, differed entirely from the whole of what he had heard, eulogized the Melbourne system, by which the solid matter was separated from the liquid, the former carted into the country and harrowed into the fields, and the latter run in open drains into the Yarra, which, of course, gave Melbourne "an advantage through its fine tidal river." The Honourable Alex. Hay, M.L.C., spoke of the stenches in the Melbourne hotel he had lately patronized, and of the "fine tidal river," down which whoever had once sailed would not wish to do so again. Dr. Bennett, of Sydney, spoke of the system in use in the capital of his colony. This paper aroused no little interest, for at the next monthly meeting Mr. G. H. Connor gave one on "Adelaide Sewerage Chemically Considered," and two months later Mr. J. L. Hyndman read a third on "The Practical Treatment of Deep Drainage, or the Application of Deep Drainage to Adelaide." The system advocated by Dr. Gosse was afterwards adopted, and some of you will remember how, at our first Intercolonial Medical Congress in 1887 we were taken down to our Sewage Farm by Dr. Whittell, then President of the Board of Health, who showed with no little pride the complete arrangements, and especially the outflowing stream of perfectly clear water from drain pipes laid several feet below the surface of the irrigated land, which land looked like the fields of Pharaoh with their fat kine feeding in green meadows.

In 1877, when a paper by C. A. Wilson, F.L.S., was read on "Chloroform, the Manner of its Discovery and Certain Facts and Results Relative to its Use," in the ensuing discussion Dr. Gosse emphasized the care and caution with which it should be used, and then only by an experienced medical man with a practical assistant, and pointed out the greater safety of ether, which had consequently, at the Adelaide Hospital, superseded it. When Dr. Chalmers at the next meeting gave a paper on influenza as it affects horses, Dr. Gosse joined in the discussion, as did also Dr. Wm. Gunson, the father of our present Acting Secretary. In 1878 a paper by H. H. Hayter, Government Statist of Victoria, on "Infantile Mortality in South Australia," was presented, Dr. Gosse was present to speak to it and dissent from some of its conclusions.

At the Annual Meeting in October, 1878, a radical change was effected in the Society, as to its name, its aims and its government. The influence of Professor Tate had made itself strongly felt. For the future it was to be called the Royal Society of South Australia; original research, and personal scientific work and personal observations in natural history were to be encouraged and recorded. Hitherto the Governors of the Province had been *ex officio* the Presidents; now they were invited to become Patrons, while the Presidents should be elected annually from among the Fellows. The first individual on whom the honour of President by election was conferred was Professor Ralph Tate, and the gentleman who proposed him was Dr. Wm. Gosse. In the following year (1879), the South Australian Branch of the British Medical Association was established, and Dr. Gosse was chosen as its first President, and, as might be expected, his name disappears from the minutes of the Philosophical Society. But his record in connexion with it was good. He was evidently regarded by his fellows as a leading spirit in his profession, and as one of the most capable, useful and reliable members of their Society.

Summary.—The account of his life, as now outlined, though incomplete and imperfect, reveals a man who impressed very favourably those who came in contact with him. The rapidity of his success was marked. He had not been here two years before he was an honorary medical officer of the hospital. Within four years he was a Visitor of the Lunatic Asylum, Member of the Central Vaccine Board and Member of the Medical Board, and within six years he was in partnership with one of the leading surgeons. Of course, we have to remember one fact. He did not come here a "callow youth," fresh from his medical school. He was nearly forty years old, had been in practice fifteen years subsequently to qualification, and doubtless "knew his way about." Still, he must have had some special endowment of mind and manner to acquire so quickly the patronage, not only of the people, but of those in power.

Another circumstance is to be noted: his tenacity and reliability. Posts accepted at his advent to the

Province, though wholly honorary, he retained till death took them out of his hands. Many another would have resigned them after a shorter or longer period of tenure, as of no further use for gain or for ambition; but he still held them, as though from habit or affection, and so vindicated his appointment to these many offices.

We notice, too, that his energies were not wholly confined to his profession. General education, in its primary department, secured his aid as a member of the Central Board. The University Senate conferred on him its Wardenship and a seat on the Council. And the Adelaide Philosophical Society made him a member of its Council, and twice honoured him as Vice-President; and of the South Australian Institute, he was a Governor for about fifteen years. There must have been some extra depth or breadth in his general knowledge to have led to such results.

Then his religion was one of his concerns, and his co-religionists, as laymen, confided to his care their interests in the government of the church.

Further, the number of institutions with the inception of which he was associated is striking and suggestive. The Board of Management of the Adelaide Hospital, the South Australian Medical Association, the South Australian Medical Benevolent Association, the South Australian Branch of the British Medical Association, the Home for Incurables, the Institution for the Blind and Deaf and Dumb, the Vaccination Board, the Board of Health, the Education Act, the University of Adelaide, the Adelaide Philosophical Society and Royal Society of South Australia. These are not enumerated as being all his personal creations, or as being instituted upon his sole initiative, but he had to do with the beginnings of every one of them; and it is remarkable in how many instances he was the man whom they first and most delighted to honour as the individual to whom they owed much, or from whom they might expect great assistance.

Doubtless, something was due to his almost courtly address and kindly manner. A person, now elderly, told me recently how, when quite young, he was examined for life assurance by Dr. Gosse, and, as he left his consulting-room, he could not help feeling he had been in the presence of a refined English gentleman. His pleasant courtesy was, however, no artificial veneer, concealing a flimsy fibre of character and capacity, but a natural polish, securing prompt respect, and the sign of underlying solid qualities of brain and heart, ensuring permanent regard. And so we feel glad, and may even be proud that our first President was Dr. Wm. Gosse, a medical man who was an ornament to our Association as well as to his profession.

THE TREATMENT OF SQUINT.[1]

By **E. Temple Smith, F.R.C.S.E., D.O. (Oxon.),**
Ophthalmic Surgeon, St. Vincent's Hospital, Sydney, etc.; Major, Army Medical Corps, Australian Imperial Force, Ophthalmologist, No. 2 Australian Stationary Hospital, Egypt.

I do not intend, as the title of this paper shows, to touch on the vexed and complex question of the ætiology of squint, but on that of its treatment only; neither to dogmatize, but to tell you how I treat squint in my own practice.

In speaking of squint, unless otherwise qualified, I mean concomitant convergent strabismus.

Two cardinal principles stand out: (1) That treatment cannot be begun too early; (2) that observation, with concurrent treatment, should be continuous until the squint is cured. This will probably be months, and may be years.

The means of treatment open to us are:—

(*i.*) Instillation of cycloplegics.
(*ii.*) Covering the good eye.
(*iii.*) Ambyloscopic exercises.
(*iv.*) Glasses.
(*v.*) Operation.

Several or all of these measures may be used in turn, or together.

When a squinting child comes for treatment, the following points are noted and recorded:—

(1) Whether constant, periodic or alternating.
(2) Whether concomitant or paralytic.
(3) Whether convergent or divergent (also any vertical factor).
(4) True or false fixation.
(5) Size in degrees, as measured by Priestley Smith's tape.
(6) The approximate duration.
(7) Vision, if possible.
(8) Refraction, and fundus examination.

When one sees a squint within a few days or a few weeks of its onset, the value of atropine, to hamper the use of the non-squinting eye, is at its highest. This, with correction, if necessary, of the refraction, especially if high hypermetropia be found, will probably prevent its development as a permanent deformity.

If the patient is a young infant, nine months is the earliest age at which one can hope to estimate the refraction by retinoscopy. I have done this and prescribed glasses to several infants of this age, and the glasses were worn with comfort.

Earlier than this, if the squint is monocular and slight, atropine in the good eye I have found to prevent its further development. When, in young children, the squint is associated with nystagmus (often due to lental or retinal changes), nothing is of avail except operation, for cosmetic reasons, which is better in such cases postponed to a later date. Here, an early operation will not save fixation power, since this has never existed, its absence being the chief factor in the production of the squint.

Let us consider a typical case of squint. A child of from three to ten years of age has a convergence of 30°, the squint has existed for several years, the eye is amblyopic, and fixation is absent or poor. There are, let us say, five dioptres of hypermetropia, spastic contraction of the internal recti and weak abversion.

My procedure is as follows: I correct the refractive error up to half a dioptre, in the case in point, 4.5 D., and atropinize the good eye once daily. If circumstances permit, I occlude it also with a pad and strapping for a month continuously. I can see no use whatever in doing so for a few hours daily, as is often

[1] Read before the Ophthalmological Society of New South Wales on February 6, 1918.

advised. At the end of a month, if there is any improvement in vision or fixation power—and the one presupposes the other—I persist in this course, seeing the child at least once a month.

If these have improved very much, amblyoscopic exercises may do good as this stage. In this connexion I may say, without depreciating the method, which is based on rational principles, that it is useless in the majority of cases of the class I am now describing (those of long duration with amblyopia). In selected and recent ones I have found it beneficial, and know that others have done so. But in hospital practice, and in most private cases too, it must remain impracticable, owing to the time it demands.

Assuming for the moment that the case is not one of those likely to repay one in its results for the time spent on orthoptic training, I continue occlusion, with or without cyclopegics to the good eye, with at least monthly examinations, until vision has ceased to improve. Fixation power will then generally have become re-established at any rate. I consider six months of such treatment and observation to be enough. If the condition is not improving, or has become stationary after a certain measure of improvement, and the squint is still over 15° with glasses, I advise operation. The child cannot grow up with one eye occluded or under cycloplegics. The newly-acquired fixation power will soon be lost, since the better eye will instinctively take up the work again. Or, if the eye is not amblyopic, it will soon become so, if it does not get a chance to work with its fellow. It is far easier to adjust a muscle than to arouse an undeveloped faculty or recover a lost one.

If the squint becomes alternate, or if it started as such, I waste no further time in treatment, but operate at once. In the former case the conditions have become ideal for an attempt at re-establishing binocular vision, and in the latter no treatment but operation will be of the least avail, as it is due to a defect of co-ordination.

I repeat, and I do it advisedly, that I am in favour of early operation, and I await criticism with an even mind.

Priestley Smith, at the Utrecht Congress, in 1898, emphasized the very early age of onset, which he showed to be frequent before four years, and even more so at two or three. The harm which arises from delay in treatment is incalculable. The most outstanding feature is loss of fixation-power, and the two most certain causes of this he showed to be early onset and long duration.

The longer treatment is delayed, the more certain it is that operation must be resorted to. The earlier cases come under observation, the less often will it be needed. But when delay has taken place before proper treatment has been sought, when the conditions described above have arisen, and when it is certain that the squint will need operation for cure, I see no use in delaying. It matters not whether the patient be two or twenty-two. But it is far more important in the former case. The older patient can only require treatment for cosmetic reasons; for the little one we may be able to save binocular vision.

The greater part of my remarks about operation refers to the majority of the cases met with, *viz.*, cases in which delay in seeking advice has occurred or inadequate treatment has been given. But I cannot refrain from quoting from the paper mentioned above Priestley Smith's views about the younger patients:—

> Take the case of the child brought when two years old, with a continuous squint and uncertain fixation-power in the squinting eye. Suppose that, by constant uses of glasses and pad we get, during the next three months, some diminution of the angle of the squint, and return of active fixation-power in the faulty eye, and then, month after month, no further progress. What shall we do? Shall we postpone operation for three or four years and try to persuade the mother to apply the pad periodically or continuously during the whole of this time? We shall almost certainly fail in this, and, in any case, there will be no development of the sense of fusion. The chances are that, by the time the child is five years old, recovery of binocular vision will be impossible. In such a case I should prefer to operate even at two years old. The operation, of course, will not interfere with further educative treatment; on the contrary, it will expedite and aid it.

My own practice has been based on this view. Squints, except slight ones, those coming under treatment early, and those in which correction of the refraction corrects the squint, do not tend to spontaneous cure ("growing out of it"), but to an amblyopic eye. The prescription of glasses for squint is not the end of treatment, but the beginning. The patients should be seen by the surgeon at intervals extending over years, whether operation be undertaken or not. At first, intervals of one month, later intervals of three, six, or twelve will be sufficient, but the patient should never be lost sight of. Most of my old hospital patients come up at varying intervals for inspection. One can thus observe one's results after long periods. I had meant to get together some statistics, but the present circumstances have made this difficult. My observations, however, are based on some hundreds of cases, seen over a period of twenty years.

Having given my views on the principles of treatment, I propose to tell you how I operate. My primary object is to shorten the external rectus muscle. To complete tenotomy, with certain well-defined exceptions, I am uncompromisingly opposed. The exceptions are divergent strabismus, for which I do a full and complete tenotomy of both external recti, and hypertropia, for which I divide the superior or inferior rectus, as the case may be.

By completely tenotomizing the internal rectus in convergent squint, we are introducing an unknown factor. We do not know how far the tendon will retract. Those who defend the measure will say that the two bad results formerly observed—of secondary divergence and sinking of the caruncle—will be avoided by those who are careful to divide only the tendon and not the lateral expansions. My objections, however, are not chiefly based on these grounds (though I recognize the dangers), but on the fact that, be it large or small, the amount of the retraction is unknown. What I am at is an approximation to accuracy. And this is got by lengthening the internus by three cuts. The method has been largely advocated by Bishop Harman. The tendon is exposed by turning down a triangular flap of conjunctiva and clearing it from its fascia. From five to eight millimetres of the tendon between two squint-hooks are

then exposed; two scissor-cuts (four or five millimetres apart) are made half way through its width on the upper side, and one on the lower, half way between these two, and two-thirds of the way through. This, by the zig-zagging of the cut tendon, permits the eye to be rotated into the new position in which it will be fixed by the procedure on the externus. It also, equally with tenotomy, puts the internus out of action for a week or so. This I call tenoplasty.

Having stitched the conjunctiva in place again, the eye is rotated inwards by a stitch at the outer limbus, and the operation on the externus is proceeded with. I have a technique for advancement which gives me good results, and which I do not expect now to alter, as it is the final outcome of many trials. This I use when operating on a tendon which has been operated on before, and often also in adults. My method of election, however, is by Bishop Harman's method of "reefing" or "tendon-tucking." Those who are interested can find all details in back numbers of the *Ophthalmoscope* and the *Transactions of the Ophthalmological Society*. I have used the method in over fifty cases, sometimes alternating it with an advancement by way of comparison. Final results have been equally good by both methods, but I prefer the "reefing," because one can more accurately forecast on the operation table what those results will be. Advancement is guesswork at the best. In reefing, one can set out to correct so many degrees of convergence, and in most cases can get just this result. Harman gives two degrees for each millimetre of shortening. I think one gets more when tenoplasty is associated with it, as I think it always should be. I prefer not to aim at more than eight or ten millimetres of shortening on any one eye. If more is needed, I operate on the other one.

At this point I may say that I always tell parents that a second operation will probably be needed for the fine adjustment. It often is not, but, if it is, the first operation is not then regarded as a failure. In squints of 30° and upwards I always prefer to divide the procedure between the two eyes.

Other points about reefing are that it is slightly quicker, it is more bloodless, there is less trauma, and there is no visible scar at a later late. Harman draws the rucked tendon forward to the limbus, in order to over-correct for a few days, and to flatten down the reef, not with any idea of permanently advancing it. I have given this up, as I think it is better to know at the time just what effect to expect, and I have not seen the advantage that he claims by this modification.

Whether the procedure on the externus is advancement or reefing, I believe the effect on the tendon to be the same. Since adhesions will form over the whole area from the cut stump to the point near the limbus, where the tendon is stitched, advancement is only one method of making the tendon shorter.

As regards the amount of correction, I aim at a slight under-correction. If one eye is amblyopic, this is the more important. One must allow for consolidation and contraction of the scar, by whatever method this is obtained. Where strong convex glasses have to be worn, I leave a few degrees uncorrected, especially if the eye is amblyopic. If there is good vision in both eyes, one may aim at orthotropia, with the reservations above. It is pleasant to have a little up one's sleeve, and it is easy to make any fine adjustment by a slight operation on the other eye, if needed, after scar-contraction is complete and glasses and educative methods have been employed. Only those who have had it forced upon them know the worry and trouble entailed by having to re-operate on an over-corrected eye.

I prefer local anæsthesia, whenever possible. Deep injections in the neighbourhood of the tendons are very effective. In private it is more often possible than in hospital practice, where one has not the time to coax and gain the confidence of the small patient. I have used local anæsthesia on quite unusually fractious children of four.

Although I have spoken strongly in favour of Harman's operation of "reefing," that is not the *raison d'être* of my paper. I regard the method of obtaining a shortening of the externus as of quite secondary importance. In any discussion that may follow, I hope that it may not centre round the best technique for obtaining a shortened externus, but that it may be focussed rather on the principles I first mentioned, *viz.*, prompt treatment, continuous observation and early operation. Do not suppose, however, that I advocate hasty or indiscriminate operation. On the contrary, in every case a persevering effort should be made to do without it, but when all progress by other means comes definitely to a standstill, and operation offers the only prospect of binocular vision, then, in my opinion, it is right to operate, and especially if the child be young.

Reports of Cases.

A FULMINANT CASE OF PUERPERAL ECLAMPSIA; CÆSAREAN SECTION; RECOVERY.

By **Judah Leon Jona, D.Sc. (Adel.), M.D., B.S. (Melb.),**
Acting Honorary Assistant Gynæcologist, Melbourne Hospital; Acting Honorary Obstetric Surgeon, Women's Hospital, Melbourne.

I am prompted to report the following case, not so much from the point of view of the immediate result (which, possibly, might have been attained by more conservative measures), as to bring under the notice of operating obstetricians the advisability of resorting more frequently to this method of terminating pregnancy in eclampsia, on account of the greater control one has over the possibility of maternal and fœtal injury. Cæsarean section for eclampsia is, I believe, resorted to fairly frequently with good results in other countries, but the method is not used very frequently in Victoria at any rate.

Mrs. T. W., primipara, *æt.* 32, had always been healthy. She engaged me on February 6, 1918, being then apparently about four months pregnant. Her only discomfort at the time was some vaginal irritation, due to local over-secretion, which soon cleared up. On February 13, 1918, the urine was clear and acid, and contained neither albumin nor sugar. The urine was re-examined, with the same result, on March 22, April 26, and June 4, 1918. On June 19, 1918, she had albuminuria and some œdema of the legs. She was put to bed, sweated, purged and treated generally, and on June 20, 21, 24 and 25 the urine showed varying amounts of albumin, but the œdema of the legs had practically disappeared by June 24, 1918, and the patient was feeling generally better. Early on the morning of June 26, 1918, she had a "show," and went into a private maternity hospital

during the forenoon. At 2 p.m. she had an enema, was feeling comfortable, but had a slight headache. She had practically no labour pains, but was feeling very nervous. At 5 p.m. she had sudden flashes before the eyes and went blind, but could distinguish light from dark. She vomited from time to time. At 5.30 p.m. there was intense headache. She was absolutely blind. On examination, it was found that the fœtus was alive, and was lying in the left occipito-anterior position, with the head not fixed. The heart-rate was 150. The mother was very nervous; her pulse-rate was about 80. *Per vaginam* the *os* was found to be barely the size of a sixpenny piece. She was given morphine, 0.017 gm. (gr. ¼). At 8 p.m. she was becoming "bloated" in the face and semi-comatose, and her breathing was stertorous. I decided to operate, as the patient's condition seemed to be becoming rapidly worse. She was therefore transferred to a surgical hospital. Half a litre of saline solution was introduced into the bowel just before she was brought in on to the operating table at 10.30 p.m., when her condition was not good. Under chloroform anæsthesia, I performed abdominal Cæsarean section, and delivered a living female child, which breathed as soon as delivered, and weighed 3.4 kilograms (7½ lbs.). The patient's general condition was good on leaving the table. At 11.30 p.m. 600 c.cm. of saline solution were put into the bowel, and rectal saline injections ordered two-hourly. At 12.30 a.m. (June 27, 1918) she recognized my voice, but was still blind and stuporous. At 2 a.m. she had a fit. She had two more fits between 2 a.m. and 7 a.m. Large quantities of urine were secreted, and were drawn off during the day. The patient objected very strongly to the catheterization. She distinguished light from dark. Her general condition was good.

On June 28, 1918, she recognized as a shadow a person moving past a window. On the following day the urine contained no albumin. Some little dysuria, especially at night. Her general condition was good. The baby was put to the breast.

On June 30, 1918, her vision was good (the room was kept darkened). She remembered nothing of her labour, or of being moved from one hospital to the other.

On July 10, 1918, she was sitting up and feeling well. She was suckling the baby, who was thriving.

LARGE OVARIAN CYST ASSOCIATED WITH FIBRO-MYOMA OF THE UTERUS.

By **Merrick O'Reilly, M.B. (Syd.),**

Honorary Medical Officer, Bega District Hospital.

Miss H., *æt.* 49, was first seen on April 30, 1918. She complained of a swelling of the abdomen, which she first noticed about four years ago. In the last month or two, it had increased rapidly. She had no other symptoms. The patient thought she might be "falling into flesh, because of the change of life."

To casual inspection the patient was a thin woman, but the abdomen was considerably larger than is usual for a full-time pregnancy. After examination, the diagnosis of ovarian cyst was made.

On May 8 the abdomen was opened by a median incision, and a large cyst was drained off. When it had sufficiently diminished in size, it was delivered through the wound, the pedicle clamped, and the sac removed. Another tumour then presented in the wound, darker and redder in colour than the cyst.

Though it felt cystic, no fluid could be drawn off through a cannula. After enlarging the incision, the tumour was delivered, and was seen to be continuous with the uterus. The whole mass was removed by a sub-total hysterectomy. The uterine tumour proved to be a fibro-myoma, containing several small cysts, which gave it the "cystic feel."

The myoma weighed 4 kilograms, and the fluid from the ovarian cyst measured 8 litres. The patient made a good recovery.

The interest of this case lies in the co-existence of the two fairly large tumours, and the fact that the presence of a large myoma was quite unsuspected prior to operation.

Reviews.

A MEDICAL FORMULARY.

The complete medical pocket-formulary[1] collated for the use of medical practitioners by Dr. J. C. Wilson, and revised by Dr. C. H. Turner, contains prescriptions collected from the practice of experienced American and other physicians and surgeons and arranged for ready reference under headings such as acromegaly, albuminuria, alcoholism, cancer, general and senile debility, myalgia, toothache and vomiting. The prescriptions are given with doses in apothecaries' measure and the metric system and directions as to use are supplied with each prescription. The author states that the book is not intended to replace text-books of therapeutics or to supplement the defects of imperfect education. He considers that the book will bring to the attention of the medical practitioner the results of the general experience of the profession, by making available a wider range of therapeutic knowledge than is usually possessed by a single person. It will also serve to refresh the memory with facts which may be difficult to recall at once. The author hopes that those who use this book, will avoid the error of forcing these formal recipes upon their patients and that they will modify these suggestive formulæ to make them suitable to the condition of the individual. The warning which the author thinks it advisable to give in his preface, emphasizes the risk involved in publishing such lists of prescriptions. The layman, the nurse or the ill-trained and inexperienced medical practitioner may be tempted, after having made a random diagnosis, to refer to the appropriate heading in this book and select haphazard one of the formulæ. Too great care cannot be exercised in preventing the indiscriminate introduction of potent pharmacological agents into the human body. It is thus satisfactory to note that ten years have elapsed since the appearance of the last edition of this formulary.

THE NOSE AND EAR.

Surgeons who have adopted the labyrinthine mazes of the nose and ear for their province will doubtless be interested in Adam E. Smith's admirable portfolio of plates representing drawings from anatomical preparations and of sections through these regions.[2] The drawings, 45 in number, are about three-quarters natural size, and are excellently reproduced in black and white. One group depicts anterior and posterior views of serial coronal sections through the head of 1 cm. thickness, from the posterior border of the anterior nares to the posterior pharyngeal wall. There are also drawings of sagittal and horizontal sections through this region. The ear sections have been made through planes well calculated to prove helpful to the surgeon, and progressive dissections from the surface in this region, on the cadaver, are drawn so realistically as scarcely to require the skeleton-repliqués, with the chief structures named, which accompany them. The text is terse, lucid, and concise, the anatomy of the parts being described especially in relation to their surgical significance. The author outlines several new surgical procedures, based wholly on anatomical findings. These include methods for the opening up of the nasal sinuses, for the removal of the pituitary gland, and for the exposure of the deep structures of the temporal bone and surrounding parts. He discusses the question of posture in the treatment of otitis media and mastoiditis, and deals with the mechanics of treatment by suction in nasal accessory sinus disease. A useful inclusion is a description of Chipault's method of brain localization, together with an illustrative diagram.

This volume is a valuable and welcome addition to our surgical book-shelf, and supplies a need.

[1] The Complete Medical Pocket Formulary and Physician's Vade-mecum, by J. C. Wilson, A.M., M.D.; Sixth Edition, Revised by C. H. Turner, M.D.; 1917. Philadelphia: J. B. Lippincott Co.; pocket size, pp. 299. Price, 12s. 6d. net.

[2] Studies in the Anatomy and Surgery of the Nose and Ear, by Adam E. Smith, M.D.; 1918. New York: Paul B. Hoeber; Crown 4to., pp. 157, with 45 illustrations. Price, $4.00.

The Medical Journal of Australia.

SATURDAY, AUGUST 17, 1918.

The Federal Committee.

The Federal Committee of the British Medical Association in Australia has been in session for two days, and has deliberated on several matters of importance to the profession and to the public. While this Committee has no powers in initiation and cannot compel the six Branches of the British Medical Association in Australia to adopt any given policy, its functions in co-ordinating the activities of the Branches and in finding ways and means to introduce uniformity of action in the medical profession on matters referred to it by one or other Branch must have a far-reaching effect for the good of the community. The introduction of the Federal Committee into the machinery of the British Medical Association in the Commonwealth is not merely a convenience of administration. It opens up the possibility of an organization of the medical profession of incomparably greater utility to the community than that which can be attained by the individual efforts of the Branches. The fact that the smallest Branch has the same representation as the largest signifies that the Committee exercises a steadying influence on the policy of the Branches. The Committee imperceptibly puts a brake on the several Branches, and, by its wider sphere of counsel, it will ultimately lead to a broader-minded outlook on questions of medico-political importance.

The experience gained since the foundation of the Federal Committee in 1912 teaches that the eventual rôle of the Federal Committee will be a bigger one than it has been in the past. The constitution of the British Medical Association is based on democracy. Every member has a full and equal vote on all matters dealt with in the Association. In the United Kingdom, where the central government of the Association is placed, each member has an opportunity of recording his vote on any question of policy referred to the Representative Body. This vote is registered within the Divisions, when the representatives receive their instructions. As is the case in all government by representation, the views of the majority in each electorate determine the policy to be adopted by the representative. For the purpose of equity, any representative in the Representative Body can demand a card vote, if he has the support of nineteen other delegates. This enables him to record one vote for each member of his constituency. In Australia, the effective application of the principles of democracy is limited by geographical difficulties. The constitution of the Association does not provide for the establishment of a body analogous to the Representative Body in the old country. The Branches have a wide autonomy, but there is a danger of autocratic rather than democratic government, since, owing to the great distances, the country districts cannot be properly represented on the Branch Councils. It is true that the members in every part of the Commonwealth have equal voting powers for the election of the members of the Branch Councils. In practice, however, the practitioners residing far from the metropolitan centres take little or no part in the management of the affairs of the Association. The election of the members of the Federal Committee and the instruction of the elected members concerning the way in which they should vote at the meeting of the Committee are not actually in the hands of the members of the Branches generally. In the future the interest in these matters of the country members will be awakened and means will, no doubt, be found for the institution of a representative meeting endowed with full legislative powers. It is apparent that uniformity of action cannot be achieved in all matters concerning the relations of the medical profession to the public until the principle of federalization has been introduced into the political government of Australia. Sooner or later the State Parliaments must surrender their legislative rights dealing with the control of the public health, with the registration of medical practitioners and with the maintenance of a high standard of efficiency in the practice of medicine, and with the adjustment of the conditions under which persons in necessitous circumstances can obtain medical attendance. No one can maintain that the relations of the medical profession and the public vary sufficiently in the different States to justify varying methods of dealing with these

matters. Until these rational changes have been effected, the medical profession can do no more than prepare the way by aiming at uniformity. But since uniformity of action involves the adoption of principles which are applicable and sound in all parts of the Commonwealth, it is clear that the Federal Committee has much pioneering work to do to prepare the way for a body entrusted with the government of the Association in the Commonwealth and the establishment of an executive body, empowered to carry out the wishes of the governing body. The Federal Committee and *The Medical Journal of Australia* have the task of educating the members of the Branches to take a federal view of all matters of general application and to recognize that no one Branch can or may determine the policy for the others. The members must be induced to distinguish between matters of local interest, with which they can deal without reference to a central committee and matters affecting the profession in its relation to the community on which a wide view should be taken. The Federal Committee has the duty of ascertaining the opinions of each section of the profession, in order that it may, in the transitional stage, apply the essential factors of democratic government without the machinery which would render this an automatic procedure. Its members are chosen from among the leaders of professional thought in the great cities, and each one should recognize the great responsibility which rests upon his shoulders and justify his selection by sinking his individuality for the benefit of the medical profession of which he is an ornament and for that of the community of which he should be councillor and guide. The Branches should exercise care in the election of the members to serve on the Federal Committee, and should test the wisdom of the choice by examining after each session of the Committee how they have discharged the duties they have undertaken. The value of the Federal Committee to the Association, to the medical profession and to the community will depend on the wisdom and judgement of its members, on the assistance they receive from the members of the Branches and on the capacity of the individuals to take a wide outlook on matters medical.

THE MEDICAL INSTITUTES.

The impasse in the dispute between the medical profession in Victoria and the friendly societies should not be formidable and should be capable of removal. His Honour Judge Wasley has decided that the demands of the medical men in regard to rates of remuneration are fair. He has approved of the establishment of an income limit, even if his suggestions concerning the fixing of the limit differ somewhat from the conditions set out in the Common Form of Agreement. Ostensibly an understanding could have been arrived at, if the friendly societies were not compromised in connexion with the newly-formed medical institutes. A frank recognition of the undesirable nature of the practice in these institutes would go a long way toward an understanding. These institutes have been established for the purpose of compelling the Victorian Branch of the British Medical Association and the medical profession in the State to desist from demanding the introduction of a uniform agreement on terms acceptable to the medical profession. They have proved an indifferent weapon to fight with. The friendly societies have endeavoured to supply medical attendance to large numbers of members by appointing medical practitioners at a fixed salary to carry out an indefinite amount of work.

The representatives of the friendly societies resent the statement that medical attendance on lodge patients implies a certain degree of charity. They have not been successful in denying that the terms of the contracts represent a very material concession on the part of the members of the profession. This concession to persons of small means is willingly given on two conditions. In the first place, there may be no abuse by the extension of the principle to those who do not need the relief, and, in the second place, the persons who benefit, the persons who object to the term charity, should pay a sum commensurate with their wages in payment for the services they claim. The ordinary and proper basis for remuneration of skilled services rendered is that of payment for work done. Medical practitioners have something to sell—the products of their brains. They set a price on this commodity and offer it to the public. Unlike the ordinary tradesman, they recognize that the same commodity, not a cheaper quality or less valuable article,

must be offered to the poorer members of the community. In the case of the necessitous, the medical practitioner undertakes to give gratuitous service; in the case of the wage-earner, he accepts a regular payment of a small sum in return for an unlimited amount of service. Theoretically, the best form of contract practice is that the premiums from each member of a friendly society are paid into a common pool, out of which the medical officer is paid a low fee for each visit or consultation. The difficulty met with in putting this scheme into operation is that the amount standing to the credit of a given member may not suffice for the medical attendance necessary. When the British Medical Association was faced with the introduction of national insurance in the United Kingdom, three modes of remuneration were considered. These were payment for work done, payment of a fixed amount per member insured, and payment by salary. Without dissent the Association refused the proposal of payment by salary, on the ground that this necessarily changed the general arrangements of practice. Experience has taught that the average medical practitioner who is engaged to carry out an unlimited amount of work for a limited amount of payment, does not give a satisfactory service. He is necessarily inclined to consider the interests of his employers before those of his patients, with the most unsatisfactory results. The recognition of this and of the fact that such an arrangement admits of the principle of the intervention of a third party between the medical practitioner and his patient, have determined reputable practitioners in objecting to the proposal and refusing to participate in it. The experience of the medical institutes in Victoria has fully justified the objection, and has demonstrated that, unless the friendly societies get rid of the medical institute, with their essential disadvantages, the self-respecting practitioners in the State will refuse to lend assistance in providing medical attendance on the lodge patients.

The friendly societies regard the matter from their own point of view. It is undoubtedly an embarrassing position to have entered into contracts with individual persons, and then to have to realize that these contracts stand in the way of an amicable settlement of the difficulties with the medical profession. The medical profession cannot be held responsible for this *faux pas*. It will probably be found to be economical to pay compensation to those whose services have been engaged for a definite term. It must be understood that the medical institutes are objected to because they are based on the wrong principle of requiring one man to provide medical attendance on conditions which practically preclude a satisfactory discharge of the duties. This form of medical practice is not in the interests of the public, and for this reason should not be conducted. The size of the salary is immaterial, since the principle is wrong. Sooner or later the position must be faced. We have no doubt concerning the view which the friendly societies and the lodge patients themselves take of the institutes.

THE DISTRIBUTION OF NORMAL ELEMENTS AND FOREIGN BODIES IN THE BLOOD.

It is usually supposed that the blood picture, as revealed by an ordinary hæmatological examination, supplies the clinician with information concerning the number of each variey of blood corpuscles in a given quantity of blood. That such an assumption is unjustified is shown by information that has been accumulated during the past fifty years. Sherrington collected much evidence, both from direct observation and from the literature, to prove that the injection of both soluble and insoluble substances into the blood stream led to the sudden disappearance of the leucocytes from the peripheral circulation and the rapid aggregation of the cells in the visceral blood vessels. It has been demonstrated in recent years that the distribution of the blood corpuscles in the circulation does not obey the ordinary mechanical laws, as is the case outside the body. The leucocytosis of digestion is not indicative of an increase in the total number of leucocytes, but depends on the attraction from the viscera into the peripheral vessels of many white blood cells. The distribution is regulated under nervous control (Lamson), although it is admitted that the mechanism of this control is not understood. No one has yet offered a plausible explanation for the retention of certain cells in the bone marrow and in the spleen under normal conditions and their liberation under the stimulation of pathological changes. A. W. Sellards and W. A. Baetjer[1] have collected many facts in connexion with this subject, and have undertaken some simple yet ingenious experiments, for the purpose of elucidating the significance of the phenomena. The injection of foreign bodies, including bacteria, into the blood stream leads almost immediately to a disappearance of the leucocytes from the peripheral blood and with them of the injected particles. The leucocytes and the particles are found in the blood vessels of the organs. The lungs and the liver attract the greater number of leucocytes. After a relatively short time, the leucocytes return to the peripheral blood. When staphylococci were injected, the interesting observation was made that the leucocytes on

[1] *Johns Hopkins Hospital Bulletin*, June, 1918.

their return to the peripheral blood contained many phagocyted cocci. In some instances the number of bacteria in the leucocytes was so great that a count became impossible. These observers recognize that in certain infections, such as enteric fever, the distribution of the bacteria in the blood is extremely irregular. Thus the rose spots rarely, if ever, appear on the extremities, while the spleen undoubtedly is more profoundly involved than the kidneys or heart. The fact that in tubercular meningitis a leucocytosis is usually met with, while miliary tuberculosis is accompanied by a leucopænia, suggests that the focus of the bacterial invasion has something to do with the determination of the abnormal distribution of the leucocytes. Their work was continued with the object of ascertaining the method of production of some of the leukæmias and, through the recognition of the disadvantage of using the peripheral blood stream for the introduction of the infective material, they have been successful in reproducing an acute temporary leukæmia in a monkey from the spleen of a man dead of acute leukæmia. The material was injected into the spleen. The rapid disappearance of bacteria from the peripheral blood in itself is of immense importance. Under ordinary circumstances, bacteria appear to have great difficulty in remaining in the peripheral blood. The study of fever and the distribution of the rash in the acute exanthemata have already thrown some light on the distribution of bacteria in the blood in some of the infective processes. Pathologists have long since realized that in all infective processes bacteria must gain an entrance into the blood stream from time to time. The tendency of the distribution mechanism to remove the bacteria from the peripheral circulation to certain viscera, and the reappearance of leucocytes loaded with bacteria in the case of massive infections are highly significant. Under the guidance of the facts elicited in this study, it should be possible to sharpen our diagnosis in conditions such as pernicious anæmia, malaria, enteric fever and many others.

LICE AND TRENCH FEVER.

The Committee appointed by the War Office to investigate the nature of trench fever have progressed farther than was reported in our issue last week. At a discussion which took place at the Society of Tropical Medicine on May 17, 1918, it was announced that the excreta of normal lice are incapable of giving rise to trench fever. It will be remembered that lice fed on trench fever patients failed to pass the disease to healthy volunteers after repeated feedings. On the other hand, the fever developed when the excreta or crushed bodies of infected lice were rubbed into a scarified area of skin of a volunteer. It now transpires that the louse is not infective during the seven days after feeding on a trench fever patient. The infective agent is more resistant than the louse itself. The excreta of infected lice do not lose their power of infection on exposure to sunlight or to a temperature of 56° C., and the virulence is seemingly unimpaired when the excreta are dried and kept for 16 days. The disease can be transmitted by the agency of lice to normal persons, without any clinical signs becoming manifest. This is proved by the fact that fresh lice, feeding on these persons, become infective and may give rise to typical attacks of trench fever after feeding on uninfected individuals. As far as the Committee has been able to ascertain, the human being is very susceptible to the infection and relatively few offer marked resistance. Moreover, the disease can be transmitted without the intermediation of lice. The urine of trench fever patients rubbed into a scarified area has given rise to an attack. The length of the latent period in the louse and the peculiar behaviour of the virus in the body of the louse is highly suggestive of it being a protozoon. It is not passed on from the louse to its own young. The next stage in the investigations will probably be directed to the study of the parasite. The Committee has undoubtedly conducted its research with despatch, and has been able, thanks to the exercise of considerable ingenuity and resource, to demonstrate some valuable facts concerning a disease which has hitherto been involved in mystery.

QUANTITATIVE ESTIMATION OF PROTEINS.

The measurement of the weight of protein contained in any material offers a troublesome problem to the analytical biochemist. The difficulty experienced in making an estimation is mainly due to the large size and low density of the molecule of protein. In consequence, the volume occupied by a given mass of protein is many times that of a similar mass of most other classes of substances. The separation of the proteins from the remaining constituents of a fluid in a state of purity sufficient for their gravimetric determination is on this account not readily accomplished. Since the percentage of nitrogen present in proteins is high, and since the analytical chemist can perform the quantitative estimation of this element with speed and precision, the measurement of a quantity of protein has been resolved into a determination of the amount of nitrogen that is present. If the protein can be separated from other nitrogenous substances their estimation can be made by the Kjeldahl process. This separation can, however, only be performed in a small number of instances with speed. In many cases a precipitation with ammonium sulphate offers the only means for isolating the proteins. Dialysis is then employed to remove the ammonium sulphate entangled in the precipitate. This dialysis occupies much time, during which a portion of the protein may pass again into solution and may be lost by diffusion.

Although proteins possess acidic and basic functions and form stable compounds with acids and alkalis, it is not possible to measure their quantity by direct titration, except in a few cases, such as those of caseinogen and of certain protamines. The amphoteric character of the compounds of protein with acid and alkali leads to secondary changes during the titration. The high combining weight of protein also renders the error by this method of considerable dimensions. The application of chemical methods for the quantitative measurement of proteins is thus inexact and unreliable, unless the particular estimation has been made the subject of special study to ascertain the

conditions under which constant figures can be obtained for the results of the analysis.

Attention has, therefore, been directed to physical methods for the same purpose. In some of these physical methods the bulk of the protein molecule is distinctly advantageous, and enhances the ease and the accuracy of the determination. Many years ago, the optical activity of the proteins was utilized for this purpose. Since the optical activity of a substance is independent of the size of the molecule, considerable error may be introduced into an estimation of protein, owing to admixture of the protein with small quantities of other optically active substance. Recently, two new methods have been employed with success. These are the nephelometric and the refractrometric methods. The nephelometric method of estimating proteins depends upon the measurement of the relative opacities of suspensions of coagulated proteins. The measurement of the opacities of the liquids is carried out in a modified form of colourimeter. The accuracy of this method depends upon the use of specific coagulating agents, which will precipitate the proteins in masses of approximately uniform size, of sufficiently wide diameter to scatter the rays of light and of insufficient weight to bring about instability of the suspension. The refractrometric method depends upon measuring the refractive index of the solution in a suitable instrument and calculating the results from the ascertained refractive indices of standard solutions of the protein. Both of these new methods have been widely employed, and seem destined to replace the chemical methods formerly used to estimate the percentage of protein.

LEAD POISONING IN CHILDREN.

A deputation of representatives of the Queensland Branch of the British Medical Association waited upon the Home Secretary of Queensland on July 12, 1918, for the purpose of asking the Minister to include a clause in the Bill to Amend the Health Act dealing with the use of lead in paint on surfaces within the reach of children. The members of the deputation were Dr. J. Espie Dods, the President, Dr. J. C. Hemsley, the Honorary Secretary, Dr. J. Lockhart Gibson, Dr. T. W. Mathewson and Dr. C. A. Thelander. The Home Secretary promised to consider the question and to determine if any steps should be taken.

On July 20, 1918, a deputation of representatives of the Master Painters' and Decorators' Association waited upon the Home Secretary to answer some of the statements which had been made by the representatives of the Branch.

At the request of Mr. J. F. Maxwell, Secretary of the Master Painters' and Decorators' Association, a conference was arranged by the Council of the Queensland Branch and the representatives of the Master Painters' and Decorators' Association. This conference was held on July 25, 1918. A full discussion took place. In the end, it was resolved that the following letter be sent to the Home Secretary:—

> At a joint meeting of the Council of the British Medical Association (Queensland Branch) and the representatives of the Master Painters' and Decorators' Association, held last night as a result of the recent deputations, it was resolved that the following representations be placed before you:—
>
> (1) That in order to prevent lead poisoning in children, it is necessary to prevent the powdering of lead paint within their reach.
>
> (2) That as the powdering occurs on fences, palisadings and verandah railings exposed to the weather, it is necessary to use a paint for these surfaces which does not easily powder.
>
> (3) That a paint be used which is manufactured on a base of not greater than 60% of carbonate of lead and not less than 40% of zinc oxide. That such paint be ground by the manufacturer, either in paste or liquid form, and must bear the manufacturer's guarantee to the effect that it complies with this regulation.
>
> (4) That the vehicle used in such paint be a mixture of genuine pale boiled oil (linseed) and genuine raw linseed oil.
>
> (5) That the surfaces specified above, and within the reach of children, must be painted every three years, in order to prevent powdering. It would be advisable that these surfaces be washed down annually.
>
> (6) That the total prohibition of white lead is unnecessary.

THE DEATH OF SAMUEL JEAN POZZI.

The dramatic termination of the distinguished career of Samuel Jean Pozzi, who succumbed to a revolver bullet discharged by a lunatic patient in his consulting-room in Paris, sent a thrill through the whole world of medicine. Pozzi's achievements as a gynæcologist and as a surgeon during the past 49 years have received international recognition. Few members of the medical profession have received more foreign honours than he, and few have more richly deserved them. He was 72 years of age at the time of his death. He was a pupil of Paul Broca, and, from the earliest period of his student life, gave promise of a brilliant future. At first he devoted himself to general surgery, but before many years had passed he drifted into the field of gynæcology, and made an indelible mark in its records. His Government commissioned him on many occasions to visit other countries on scientific missions. His skill, urbanity, polished address and sound judgement compelled his colleagues in England, the United States, Italy and other countries to hold him in high esteem. He was President of the Surgical Society of France for some years, President of the Congress of Gynæcology which was held in Marseilles in 1898, and a Vice-President at the International Congress of Gynæcology (Paris), 1900. The College of Surgeons of England marked their respect for him by electing him an honorary Fellow. His ability as a teacher and as a writer has ensured that his influence on gynæcological practice will not end with his sudden death. Every student on gynæcology must render himself aware of Pozzi's work, if he wishes to master his science.

EYE, EAR, NOSE AND THROAT CONGRESS.

October 30-November 2, 1918.

Medical practitioners who propose to be present at the Eye, Ear, Nose and Throat Congress, which is to be held in Melbourne from October 30 to November 2, 1918, are requested to intimate their intention as soon as possible to Dr. M. Lynch, 137 Collins Street, Melbourne.

The following papers have been promised:—

Dr. J. Lockhart Gibson: "Lead Poisoning."

Dr. W. N. Robertson: "Asthma and Allied Neuroses"

Subjects for general discussion:—

Eye: (i.) Iritis; (ii.) Trachoma.

Ear, Nose and Throat: (i.) Suppuration of the Middle Ear; (ii.) Nasal and Post-nasal Catarrh, So-called, Causes and Treatment.

Those who wish to read papers are asked to communicate with Dr. E. L. Gault, Collins Street, Melbourne (Eye), or Mr. W. Kent Hughes, Collins Street, Melbourne (Ear, Nose and Throat).

The death of Dr. David Skinner, of Beechworth, Victoria, after a short illness, took place on August 7.

The body of Dr. James Ivey Ingham, of Dimboola, Victoria, has been discovered floating at St. Kilda.

Abstracts from Current Medical Literature.

OPHTHALMOLOGY.

(47) Cerebral Tumour.

Arnold Knapp reports the case of a tumour of the frontal lobe with ocular symptoms (*Archives of Ophthalmology*, January, 1918). The patient, aged 36, complained of loss of sight. The vision of the right eye was $^{20}/_{30}$, and of the left $^{2}/_{200}$. The optic discs were atrophic, the left more than the right. The fields showed a central scotoma in both eyes, with gross contraction in the left. Six months later the sight was much worse and the fields further reduced. Radiography demonstrated bone absorption in the *sella turcica* and anterior fossa. The patient died three hours after an exploratory opening. At the autopsy a tumour measuring 5 cm. × 6.25 cm. was found in the right temporal lobe, springing from the *dura* on the convexity and the *falx*. It was readily shelled out, its operability thus being demonstrated. It proved to be an endothelioma. The optic nerves were flattened, and the third ventricle dilated. Frontal tumours at the base are known to produce optic neuritis, optic atrophy, ocular paralysis, and exophthalmos, while pressure farther back causes hemianopsia. In 61 cases Martin found optic neuritis in 31, no change in 10, unilateral optic neuritis in three, late optic neuritis in seven and atrophy in ten. In eight cases the optic neuritis was more marked on the side of the tumour and in two more marked on the opposite side. Unilateral optic neuritis in brain tumour indicates a basal localization. Atrophy on one side, with neuritis on the other, indicates a tumour anterior to the chiasma, which has compressed one nerve and caused atrophy. The choked disc is prevented on the affected side by the tumour shutting off communication with the intervaginal space of the optic nerve.

(48) Homonymous Hemianopsia with Hypophyseal Tumour.

Clifford B. Walker and Harvey Cushing have now collected 271 cases of pituitary disease, of which 183 showed tumour manifestation and 148 showed field disturbance (*Archives of Ophthalmology*, March, 1918). This disturbance was bitemporal in 47 cases and homonymous in 22 cases. The remaining 79 patients were blind in one eye, and therefore the grouping is doubtful. Homonymous hemianopsia has been regarded as unusual in these conditions, and few neurologists would make a diagnosis in the absence of the bitemporal defect. Bitemporal hemianopsia results from a symmetrical struma of the hypophysis; the pressure is also upon the uncrossed fibres, but they escape; the crossed fibres, by their decussation and entanglement, are rendered more vulnerable under pressure and tension. Scotomata of the caecocentral type may be the result of hypersensitiveness, or possibly toxic œdematous action, or both. The "temporal island" may be explained by the "knee" of crossed fibres which loop far forward to the opposite side of the chiasma, and escape their share of the tension and strangulation. The growths producing the bitemporal defect are not so hard or large, or rapidly growing, as those which produce the homonymous field. A growth may lean decidedly towards one tract or the other; if this occurs after bitemporal defects have been established, one eye becomes quite blind, but if the condition is seen early enough, and especially if pressure is upon the outer side of the tract, homonymous hemianopsia is met with. In addition, there are numerous variations, even to the most bizarre, from tumour invasion of this region. Several cases are described in detail, with results of operation. Sometimes a cure is effected, but, as a rule, in this group the results are not as good as in the bitemporal cases.

(49) Siderosis with Dilatation of the Pupil.

Ivor Ll. Tuckett reports a case of siderosis with pupil dilatation that goes to prove that the iron salts injure the third nerve rather than stimulate the sympathetic; indeed, the latter fibres are injured also, as shown by the fact that, after recovery, the pupil refused to dilate with cocaine (*British Journ. Ophthalm.*, February, 1918). The patient was admitted five months after the onset of symptoms; there was no definite history of any accident. The left pupil was dilated and inactive; there was a faint mottled appearance over the lens and some vitreous opacity, and a black mass in the retina, which was shown by X-rays to be a foreign body. The vision was $^{6}/_{12}$. After three unsuccessful attempts with a Haab giant magnet, the body was finally extracted with a new Mellinger magnet. Vision improved to $^{6}/_{9}$, and later to $^{6}/_{6}$. The pupil contracted to eserin, and finally regained its response to light. In dim light it did not dilate so well as the right pupil.

(50) Uveo-Parotitis with Irido-Cycloplegia.

George Mackay reports the case of a woman of 30 who, for a fortnight, complained of failing sight (*Brit. Journ. Ophthalm.*, October, 1917). On examination conjunctival and slight ciliary injection was found. The pupils were dilated to 6 mm. and were immobile. There were a few posterior synechiæ and deposits in the back of the cornea and haziness of the vitreous; vision was $^{5}/_{60}$, $^{6}/_{60}$. Tests for syphilis and tuberculosis were negative. About five days later she developed bilateral swelling of the pre-auricular portions of her parotid glands. The temperature, at its highest, was 37.5° C.. After two months the sight began to improve, and when seen a year later the vision was $^{6}/_{12}$. Ocular complications of parotitis include conjunctivitis, keratitis, irido-cyclitis, optic neuritis, optic atrophy, paralysis of the extraocular muscles, and more rarely mydriasis and paralysis of accommodation. The prognosis is usually good. In the reported cases the symptoms almost always follow the affection of the parotid, though in one instance iridocyclitis and optic neuritis preceded the swelling by a week. The author has found records of only six cases of dilated pupils and paralysed accommodation in association with parotitis. There is some justification in the belief that there may be another ætiological factor than mumps in these cases.

(51) The Appearance of the Fundus During Temporary Blindness.

A. W. Ormond had the opportunity of observing the fundus of a patient during an attack of temporary blindness (*Brit. Journ. Ophthalm.*, May, 1918). The patient had been complaining of seven or eight of these attacks in the right eye during five days; they lasted about a minute, and were unaccompanied by pain or headache. During the interview one came on. The pupil enlarged to 7 mm., the optic disc was blanched and the surrounding retina. The veins alone appeared to be present, and were notched. As the attack passed off the arteries appeared twisting around the vein, thus explaining the notched appearance. The author has no doubt he was watching a contraction of the central retinal artery. No organic disease was discovered, but a sedentary occupation and excessive cigarette smoking may have been predisposing causes. He recovered after treatment.

(52) Injury to the Eyeball Followed by Tetanus.

Robert Sattler relates the case of a man who was struck in the right eye by a punch shaped arrow of desiccated horseweed newly pulled out of the ground (*Archives of Ophthalmology*, January, 1918). Within 13 hours he was seen at the hospital, and it was found that the entrance wound was confined to the cornea, with mangled iris and lens substance protruding. Œdema of the eyelids and conjunctiva and an opalescent discharge indicated vicious infection. Enucleation was advised, and immediately carried out. On the third day symptoms of tetanus appeared, and, in spite of energetic serum treatment, the patient died on the seventh day. The case is remarkable in that the injury was confined to the eyeball.

LARYNGOLOGY AND OTOLOGY.

(53) Primary Tuberculosis of the Faucial Tonsils in Children.

The frequency of primary tuberculosis of the faucial tonsils and its connection with other tuberculous affections, more particularly with the frequent involvement of the cervical lymph glands, formed the object of a research by A. Philip Mitchell (*Journ. of Laryng., Rhin., Otology*, January and February, 1918). The material was drawn from surgical operations, and dissected under sterile conditions. The

central portions, or indurated areas, if present, were treated with ericolin to destroy bacteria other than tubercle bacilli, and then subcutaneously inoculated into guinea-pigs. These were killed in from four to six weeks, and cultures made from the spleen or lumbar glands on Dorset egg media, coloured with alcoholic basic fuchsin. No difficulty was found in differentiating the cultures into bovine and human types. The rest of the tonsillar tissue was cut into serial sections for microscopic examination. The author considers that histological examination of the whole tonsil is entirely reliable as a diagnostic method, the percentage of lesions found being greater than in the inoculation experiments. No diagnosis of tuberculosis can be made from a naked eye inspection of the tonsil *in situ* or after removal. Its size gives no clue. In a series of 106 cases with tuberculosis of the upper deep cervical glands, 41 were found with tubercular lesions in the tonsils. These lesions were found either immediately under the surface epithelium and near the mouth of the lacunæ (the most usual site), in relation to the deeper portion of the crypts, or deep in the tonsil, close to the capsule. In the next series of 100 cases of hypertrophied tonsils, invariably accompanied by palpable glands behind the angle of the jaw (these latter being enlarged from toxic absorption and not from bacillary infection), nine gave evidence of tuberculosis, the lesions resembling those of the first series in character and disposition. With the inoculation test, of 92 cases of the first series investigated, 20 proved positive (21%), the bovine bacillus being present in 16, the human in four cases. Of the second series of cases, nine gave positive results (9%), the bovine bacillus occurring in four, the human in two, the types not being determined in the other three. In a previous inquiry the author had found that 20% of the milk-supply in the neighbourhood from which the patients were drawn, contained tubercle bacilli, hence such milk may be a frequent source of infection, as 90% of the cases under five years were in bottle-fed babies, and the milk was not, as a rule, sterilized. In not a single case of bovine tonsillar tuberculosis was there a history of pulmonary tuberculosis in other members of the family, and in no case did any patient exhibit evidence of tuberculosis in the lungs or elsewhere. The author asserts that tonsillectomy is essential in all cases of tuberculous cervical adenitis in children, and advises removal of the glands first. He also recommends excision of hypertrophied faucial tonsils when complicated by considerable enlargement of the tonsillar lymphatic glands.

(54) Tonsillectomy.

With an experience of 200 cases of tonsillectomies under local anæsthesia, Oscar Wilkinson outlines his technique (*Laryngoscope*, September, 1917). Preparation of patient. An aloin, belladonna and strychnine pill or saline laxative is given two days prior to operation. The throat should be free from inflammation. A 15% alcoholic solution is used as a cleansing gargle for several days. No food is given the morning of the operation. Just before operation 3 cgrs. of codeine sulphate (at times with 0.3 mgr. of atropine sulphate added) are given hypodermically. Anæsthetic: A 6% solution of cocaine is painted over the tonsil, into the crypts and over the soft palate and pharynx. The injection consists of a 1% solution of alypin, or novocaine, or 0.1% solution of cocaine to which 5 to 8 drops of adrenalin have been added. Alypin and novocaine are preferable to cocaine. One half cubic centimetre of the solution selected is injected into the anterior superior surface of the tonsil proper, followed by two or three drops in each of the following positions in order: just under the mucosa of the *plica supra tonsillaris*, under the mucosa of the middle posterior surface, of the middle anterior surface and of the base of the tonsil. The middle of the tonsil is grasped and is drawn forward and inward and 10 drops are injected beyond the superior portion of the tonsil at the back of the capsule, then behind the tonsil about its centre, and then at the back of the tonsil near its base. The opposite tonsil is now treated similarly, by which time the first prepared is ready for operation. The entire amount of solution used is 7 to 10 c.cm. Operation: With the patient sitting upright the tonsil is grasped near its superior free border with tonsil forceps and drawn inwards and forwards, the mucosa only is incised along the superior, anterior and posterior borders of the tonsil with a sharp knife. A second forceps now grasps the superior portion of the tonsil at the margin of this incision and a dull knife is employed to scrape back the tissues from the tonsillar capsule until the tonsil is merely attached by mucous membrane below. A snare with a small loop of No. 8 piano wire is used to complete the removal. Any bleeding is controlled by pressure, hæmostatic, etc.; the cavity is swabbed with phenol and iodine solution, then compound tincture of benzoin. When both tonsils have been removed the patient is sent to bed. After care: Pain is treated with ice-packs to neck, or codeine hypodermically or by mouth; one or two doses of potassium bromide are useful for nervous patients. Atropine may be indicated in excessive salivary secretions. Cleansing gargles are used and antiseptic applications at times until wounds heal.

(55) The Monochord.

The upper tone limit is fairly constant and can be accurately determined, both through air and bone, by the monochord, described by W. M. Mollison as a length of piano-wire stretched between two points on a steel frame, on which runs a bridge; this bridge grips the wire and so alters the effective length of wire thrown into vibration (*Proc. Roy. Soc. Med., Otol. Sect., Journ. Laryng., Rhin., Otology*, September, 1917). Longitudinal vibrations are produced by rubbing the wire with resined leather or with cotton-wool soaked in spirit. The note produced depends on three factors only: (1) length of wire thrown into vibration, (2) calibre of wire, (3) the material. These three factors are easily standardized, producing an instrument which always gives the same note and requires no complicated standardizing like Galton's whistle. For bone tests the frame is held against the mastoid. The results of the tests are expressed in lengths (centimetres) of wire, that of air being placed above that of bone, *e.g.*, the average upper tone limit would read $^{15}/_{11}$.

(56) Endorhinoscopy.

In the January, 1918, number of the *Journal of Laryngology, Rhinology and Otology*, Macleod Yearsley recommends the use of the Holmes's electric nasopharyngoscope for endorhinoscopic work. He applies a 5% solution of cocaine to the lower part of the nasal septum before instrumentation. The tube is passed through the nose like an Eustachian catheter, the light switched on, and, by turning the instrument, every part of the nasopharynx can be examined. Then the tube is slowly withdrawn through the nose, and each part explored by turning the beak in different directions. Septal crests and spurs, as well as polypi, invisible by anterior rhinoscopy, can be thus displayed; pus has been seen exuding from the sphenoid sinus, and the maxillary antrum explored through an operation opening.

(57) Ossiculectomy in Chronic Adhesive Otitis.

For the relief of intolerable *tinnitus aurium* in patients with chronic adhesive otitis, A. J. Brady has performed ossiculectomy three times (*Journ. Laryng., Rhin., Otology*, February, 1918). In each case the drum-membrane was opaque, thickened, and indrawn, and the position of the ossicles suggested the contraction of adhesive bands drawing the ossicles inwards and exerting pressure on the intra-labyrinthine fluid. In the first case the drum-membrane, malleus and incus were excised, giving relief of the tinnitus and gradual improvement in hearing. After twenty years the patient could hear ordinary conversation with this ear, and did not complain of tinnitus, and the ear was completely epidermized, dry and clean—an example of well-maintained and permanent improvement. In the second case complete relief of tinnitus and restoration to normal hearing followed excision of the drum-membrane and division of the tensor tympani, but the after history of the case was unobtainable. In the third case no improvement followed operation.

(58) Pupil-Reaction Test for Deafness.

On the assumption that any sensory stimulus will cause dilatation of the pupil, Dundas Grant commends, as a test by psychic deafness, the blowing of a whistle or motor-car hooter behind the patient, while closely observing the pupil, which must be contracted by light (*Proc. Royal Soc. of Med., Otol. Sect., Journ. Laryng., Rhin., Otology*, February, 1918).

AUSTRALASIAN MEDICAL PUBLISHING CO., LIMITED.

Annual Meeting.

The annual general meeting of members of the Australasian Medical Publishing Company, Limited, was held in the Library of the New South Wales Branch of the British Medical Association, 30-34 Elizabeth Street, Sydney, on August 6, 1918. The following is the report of the Directors:

Directors' Report.

The Directors submit their Report for the past year and Balance Sheet, as at June 30, 1918, together with Profit and Loss Account for the twelve months ended June 30, 1918.

Despite the continuance of the war, which has now entered upon its fifth year, and the many consequent embarrassments affecting the business side of newspaper management, *The Medical Journal of Australia* has appeared regularly, week by week, without interruption. From the scientific standpoint the *Journal* has maintained the high standard it has established for itself, and its general usefulness to the profession and the public has been satisfactorily upheld.

Dr. A. J. H. Saw and Dr. G. Sprott retire from the Board of Directors, in accordance with requirements of the Articles of Association, and are eligible and offer themselves for re-election.

W. H. CRAGO, Chairman.

Dr. A. J. H. Saw and Dr. G. Sprott were duly re-elected Directors of the Company.

Naval and Military.

CASUALTIES.

It is with much satisfaction that we are able to announce that the 422nd list of casualties, issued on August 12, 1918, does not contain the names of any medical officers of the Army Medical Corps.

HONOURS.

The following notices concerning the awards of the Distinguished Service Order and of the Military Cross have been republished in the *Commonwealth of Australia Gazette*, No. 120, of August 7, 1918, from the *London Gazette* of March 22, 1918. The awards have already been announced in *The Medical Journal of Australia*.

Awarded the Distinguished Service Order.

Major Sydney Vere Appleyard, A.M.C. For conspicuous gallantry and devotion to duty. He established a forward dressing station immediately in rear of the front line during an attack, and attended continuously to the wounded, frequently going out and dressing cases in the open under heavy shell fire. His dressing station was hit by a shell, and, though he was badly shaken, he continued his work with great determination and devotion to duty. His fearlessness was an inspiration to all, and was the means of saving many lives.

Major William Wallace Stewart Johnston, M.C., A.M.C. For conspicuous gallantry and devotion to duty. While the enemy were shelling very heavily the positions where assaulting troops were assembled, he went out into the open with an absolute disregard of personal danger and attended to the wounded where they lay. After the attack was launched he continued to work for several hours under a very heavy enemy barrage, until severely wounded. On many previous occasions his fearlessness and devotion to duty while acting as regimental M.O. have been most conspicuous.

Awarded the Military Cross.

Captain Vernon Carlisle Brown, A.M.C. For conspicuous gallantry and devotion to duty when working at an advanced post. When the officer in charge of the post and a stretcher-bearer were wounded he attended to them under a heavy bombardment, and assisted in carrying them to a place of safety. He showed great courage and coolness.

Captain Charles Hallily Kellaway, A.M.C. For conspicuous gallantry and devotion to duty. For twenty-four hours following the attack he worked without a moment's respite, dealing with the wounded of five battalions in addition to his own, and at the same time controlling the work of his stretcher-bearers.

Captain Patrick Joseph Francis O'Shea, A.M.C. For conspicuous gallantry and devotion to duty. While in charge of stretcher-bearers he displayed the utmost courage and devotion under heavy shell fire. His fine example was largely responsible for the maintaining of the lines of evacuation from the front line to the head-quarters.

APPOINTMENTS.

The following appointments, etc., have been notified in the *Commonwealth of Australia Gazette*, No. 117, of August 3, 1918:—

Permanent Naval Forces of the Commonwealth (Seagoing).

Temporary Surgeon Robert Thomas Francis Davies Roberts, M.B., R.N., is appointed Surgeon for temporary service, as from 14th June, 1918, with seniority in rank of 29th December, 1917.

Australian Imperial Force.

Army Medical Corps.

To be Colonels—

Lieutenant-Colonel (temporary Colonel) A. E. Shepherd. Dated 26th April, 1918.

Lieutenant-Colonel (temporary Colonel) M. H. Downey, D.S.O. Dated 26th April, 1918.

Lieutenant-Colonel (temporary Colonel) J. A. Dick. Dated 26th April, 1918.

Lieutenant-Colonel (temporary Colonel) H. A. Powell, C.M.G. Dated 26th April, 1918.

To be Lieutenant-Colonels—

Major (temporary Lieutenant-Colonel) H. V. P. Conrick, D.S.O., 8th Field Ambulance. Dated 1st May, 1918.

Major (temporary Lieutenant-Colonel) A. M. Wilson, 7th Field Ambulance. Dated 2nd May, 1918.

Major (temporary Lieutenant-Colonel) D. D. Cade, D.S.O., 3rd Field Ambulance. Dated 2nd May, 1918.

Major (temporary Lieutenant-Colonel) G. W. Macartney, 10th Field Ambulance. Dated 2nd May, 1918.

Major (temporary Lieutenant-Colonel) A. F. Jolley, 9th Field Ambulance. Dated 2nd May, 1918.

Major (temporary Lieutenant-Colonel) J. H. Anderson, C.B.E., Assistant Director Medical Services, Administrative Head-Quarters, Australian Imperial Force. Dated 2nd May, 1918.

Major (temporary Lieutenant-Colonel) A. L. Buchanan, No. 2 Australian Auxiliary Hospital. Dated 2nd May, 1918.

Major (temporary Lieutenant-Colonel) A. H. Gibson, 12th Field Ambulance. Dated 2nd May, 1918.

Major (temporary Lieutenant-Colonel) H. L. St. V. Welch, D.S.O., 6th Field Ambulance. Dated 2nd May, 1918.

The undermentioned officers are granted the substantive rank of Major whilst engaged with Sea Transport Staffs, as from the dates stated:—

Captain (temporary Major) W. B. Ryan, No. 1 Sea Transport Staff. Dated 28th July, 1916.

Captain (temporary Major) W. R. Clay, No. 2 Sea Transport Staff. Dated 28th September, 1916.

Captain (temporary Major) H. H. Griffiths, No. 3 Sea Transport Staff. Dated 17th November, 1917.

Captain (temporary Major) G. G. Nicholls, No. 4 Sea Transport Staff. Dated 19th January, 1918.

Captain (temporary Major) F. Curtis-Elliott, No. 7 Sea Transport Staff. Dated 12th February, 1918.

CHANGES IN ADMINISTRATION.

The year 1918 has seen a number of important changes in the administration of the medical services throughout the Empire. In January Surgeon-General Sir Alfred Keogh retired from the position of Director-General of the Army Medical Services in Great Britain. A short time later the Director-General, Medical Services, of the Army Medical Corps in Australia, Surgeon-General R. J. H. Fetherston, handed over his duties to Surgeon-General G. Cuscaden and undertook a mission to the various seats of war and to England for purposes connected with the medical arrangements of the Australian Imperial Force. In June Sir Arthur Sloggett reached the age-limit for service on the active list, and was consequently forced to retire from the onerous position of Director-General of Medical Services on the Western Front. Sir Arthur Sloggett is a man of exceptional ability, and all who served under him recognize both the value of his work and the excellent manner in which he discharged his duties. He was always courteous; he realized the advantage of utilizing the brains of experts in the various branches of military medicine, and he was essentially fair in all his dealings. His successor, Lieutenant-General C. H. Burtchaell, entered upon his duties with a fine reputation, both from the military and from the medical point of view. While these changes have been effected in the Army Medical Service of Great Britain, a further alteration in the administration of the Army Medical Service of the Australian Imperial Force has taken place. Surgeon-General Sir Neville Howse, Director-General, Medical Services, has applied for six months' furlough, and will shortly return to Australia on holiday.

Public Health.

NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending August 3, 1918:—

	Metropolitan Combined District. Cs.	Dths.	Hunter River Combined District. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Enteric Fever	3	0	0	0	3	0	6	0
Scarlatina	10	0	1	0	8	0	19	0
Diphtheria	33	0	10	1	42	0	85	1
*Pul. Tuberculosis	28	10	2	0	1	0	31	10
C'bro-Sp'l Menin.	0	0	0	0	1	0	1	0
Poliomyelitis	2	0	0	0	0	0	2	0

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending August 4, 1918:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Total Cs.	Dths.
Scarlatina	32	0	29	2	61	2
Diphtheria	110	4	52	1	162	5
Pulmonary Tuberculosis	18	4	7	3	25	7

QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending August 3, 1918:—

Diseases.	No. of Cases.
Enteric Fever	1
Scarlatina	12
Diphtheria	58
Pulmonary Tuberculosis	16
Puerperal Fever	1
Anchylostomiasis	1

SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, Adelaide, during the week ending July 27, 1918:—

	Adelaide. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Enteric Fever	0	0	2	0	2	0
Scarlatina	1	0	9	0	10	0
Diphtheria	1	1	32	0	33	1
Pulmonary Tuberculosis	0	0	2	4	2	4
Erysipelas	0	0	2	0	2	0
Pertussis	0	0	11	0	11	0

WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the week ending July 27, 1918:—

	Metropolitan. Cases.	Rest of State. Cases.	Totals. Cases.
Scarlatina	10	4	14
Diphtheria	10	24	34
Pulmonary Tuberculosis	4	0	4
Malaria	1	0	1
Erysipelas	3	0	3

TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the fortnight ending August 3, 1918:—

Diseases.	Hobart. Cases.	Launceston. Cases.	Country. Cases.	Whole State. Cases.
Enteric Fever	0	1	5	6
Diphtheria	2	3	25	30
Pulmonary Tuberculosis	1	0	7	8
C'bro-Spinal Meningitis	0	0	1	1

THE PUBLIC HEALTH ADMINISTRATION IN NEW SOUTH WALES.

The annual report of the Director-General of Public Health of New South Wales for the year 1916, together with the appendices, is a volume of 252 foolscap pages. The part dealing with the administration of public health measures occupies 50 pages, that concerned with the local health programme of Sydney, Newcastle and Broken Hill occupies another 40 pages, the account of the variola outbreak covers four pages, the section devoted to the State hospitals absorbs another 56 pages, and the last 84 pages embrace a report of the Bureau of Microbiology. The cost of the production is not published.

The Director-General of Public Health points out that there is urgent need for the amendment and consolidation of the *Public Health Act*. This Act is based to some extent on the *Public Health Act, 1875* (England). He holds the opinion that the administration of public health measures is rendered considerably more difficult by the fact that other legislative enactments, such as the *Local Government Act*, the *Dairies Supervision Act*, the *Noxious Trades Act*, the *Cattle Slaughtering Act*, etc., supplement the main Act in several particulars. The provisions of the *Local Government Act* deal largely with public health matters, but its administration is not in the hands of the public health authorities. He pleads for the introduction of one comprehensive Act, which should be sufficiently elastic to enable the Board of Health to carry out its duties under regulations rather than under hard-and-fast legislative provisions.

Infective Diseases.

A chapter in the introductory report of the Director-General, dealing with the incidence and means of control of infective diseases is supplemented by tables, charts and other information contained in a separate part of the report.

Enteric Fever.

During the year 1916 the total number of cases of enteric fever notified throughout the State was 1,742, as compared with 1,941 in 1915. Enteric fever has been notifiable in New South Wales since 1898. During the 19 years the incidence has gradually been reduced. The averages for the five-year periods 1898-1902, 1903-1907, 1908-1912 and 1912-1916 reveal the diminution better than the more or less irregular annual returns. The figures are as follow: 2,974.6, 2,759.2, 2,385.2 and 2,056. It will thus be seen that a decrease of 30% has been effected during the course of the 19 years. In the Metropolitan Combined District there were 653 cases, with 74 deaths, which represents a case mortality of 11.33%. In the Hunter River Combined District there were 105 cases and 21 deaths, which is equivalent to a case mortality of 20%; while in the remainder of the State there were 984 cases and 114 deaths, which yields a case mortality of 11.57%. Unfortunately, no information is given concerning the incidence of enteric fever in the urban and rural districts during the past 19 years. The Director-General points out that the reduction is highly satisfactory, and that it represents the outcome of the Department's insistence on effective sanitary measures being enforced by the local authorities. The difficulties connected with the control of the disposal of excreta and with the provision of a safe and satisfactory water supply are undoubtedly very great in remote country districts, but it should not be beyond the power of the public health authority to reduce the incidence of this preventible disease in the large city areas.

The Director-General calls attention to the fact that enteric fever was again prevalent at Broken Hill. There were 146 cases during the year. The Department offered to carry out free inoculation against this disease, but advantage was not taken of this offer. Apparently, the local health authority has neglected its duty in providihg modern sanitation, and the citizens of Broken Hill have still to be taught the importance of the proper means of dealing with excreta.

It is reported that the incidence of the disease at Forbes has fallen as a result of prophylactic inoculation. Nevertheless, 41 cases have occurred, which is relatively high for a town with a population of about 5,000.

Diphtheria.

The total number of cases of diphtheria notified in the State during the year was 6,588. In the year 1915 it was 5,838, while in 1913 it was 6,380. The incidence of this disease has increased very materially during the nineteen years during which it has been notifiable. The yearly averages of each five-year group were as follows: 1898-1902, 927.8; 1903-1907, 1,301.2; 1908-1912, 3,926.6; 1912-1916, 6,017.6. A curve plotted with the number of cases in the abscissa and the years in the ordinate reveals that between 1898 and 1907 the incidence tended to remain at the same level; from 1908 to 1913 there is a very steep rise, and since that year the level has tended to remain around the 6,000 level. The deaths have also increased in number in an alarming manner, although the curve shows that the definite increase commenced later than the increase in the frequency of the disease. The case mortality for the year works out at 4.68%. It was 11.3% in 1898, and ten years later it was 6.15%. The Director-General points out that this disease is not dependent for its spread on insanitary conditions. This is undoubtedly true, but other measures besides the improvement of sanitation are available to the hygienist in the prevention of disease. Diphtheria is a preventible disease, and in many parts of the world epidemics have been promptly and completely controlled by the adoption of stringent measures. It is extremely disappointing to find that the case mortality of a disease which, when treated in the first day of illness, can be prevented from killing, still remains high, while the disease itself becomes more prevalent. The remedy is in the hands of the medical profession.

Scarlatina.

Scarlatina is passed over without a word in the introductory report. From the statistical tables it appears that the incidence is extremely high. There were 5,759 cases in 1916. In the year before there were no less than 8,335 cases. Grouped in periods of five years, the averages show an irregular incidence. In the period 1898-1902 the average number of cases per year was 2,384.8; in the period 1903-1907 it was 3,367.8; in the period 1908-1912 it was 1,991, and in the period 1912-1916 it was 3,816.6. The deaths have varied considerably. The number in 1916 was 107, which yields a case mortality of 1.85%. In 1900 the case mortality was 1%, and in 1908 it was 0.42%. On the other hand, it was as high as 3% in 1902. These figures indicate that scarlatina should be regarded seriously from the point of view of prevention.

Anterior Poliomyelitis.

The Director-General records the occurrence of an epidemic of anterior poliomyelitis. There were 294 cases notified, including 181 within the metropolis. The total number of cases notified in the year was 311. There were 11 deaths, which gives a case mortality of 6.75%. In the three preceding years the numbers of the cases reported were 47, 79 and 63 respectively. There seems to be ground for suspecting that the number of notifications does not coincide accurately with the total number of cases. In mild cases the assistance of a medical practitioner is often not sought, and in atypical cases the disease may be unrecognized. The occurrence of the epidemic of cases of an aberrant type of poliomyelitis at Bourke and elsewhere in New South Wales and Queensland demonstrates the difficulty that may be experienced in arriving at an exact diagnosis. Notwithstanding the extensive experience of epidemics of this disease in different parts of the Commonwealth and of the world generally, but little is known concerning the method of spread, and still less of the prophylaxis.

Malaria.

Malaria was made notifiable in March, 1915. In that year 105 cases were reported, and there were two deaths. In 1916 there were 61 cases and two deaths. Notwithstanding the large size of the report, the only information concerning these cases given is that 58 of them were notified in the metropolitan district.

Cerebro-Spinal Meningitis.

The Director-General records that the outbreak of cerebro-spinal meningitis of 1915 was continued during the year 1916, but that its severity was lessened. It was confined to a great extent to the vicinity of the military camps. The total number of cases reported was 309. Of these, 145, or 46.92%, were fatal. There were 132 cases, with 72 deaths, in the metropolitan area, while of the 163 cases in the municipalities and shires outside the metropolitan and Hunter River districts, 14 were in Broken Hill, 15 in Cootamundra, 26 in Goulburn, and 12 in Kiama. The disease first became notifiable on October 11, 1915, and in the eleven and a half weeks until the end of the year 50 cases, with 33 deaths, were notified. From the prophylactic point of view, the carrier problem still occupies the most prominent position, and it is in this direction that progress is expected to arise.

Tuberculosis.

In 1904 pulmonary tuberculosis was proclaimed a notifiable disease in the city of Sydney; in 1915 the notification was extended to the whole of the Metropolitan and Hunter River Districts, while in the latter part of 1916 the operation of the Act was extended to the Blue Mountain Shire and Katoomba Municipality. The reason for this slow extension is given by the Director-General. He considered it advisable to limit the application of the provision to the most densely populated areas, until it could be ascertained whether notification of this disease would cause hardship to the unfortunate sufferers. He states that no complaints of any harshness caused by the administration of the Act have been received, and consequently he proposes to extend its provisions to the whole of the State when conditions are more settled. The majority of hygienists throughout the world have come to the conclusion that the notification of pulmonary tuberculosis is an essential for the control of this disease. Since the steps taken to combat dangerous infective processes are in the interests of the community in general, the convenience of the individual is not usually taken into account. Even the infliction of occasional hardship to one or more persons does not appear to be a valid reason for the non-adoption of this measure. Once it has been determined that notification is necessary, the fact that the country is disturbed to some extent (we fear that the disturbance is not as great as it should be) by the war should rather impel the authorities to precipitate the action, than to defer it. Military service without doubt is an ætiological factor in tuberculosis, and, further, it is essential that the amount of incapacity that will remain after the end of the war, should

be reduced as far as human power can direct. In the circumstances, the number of cases notified in portions of the State cannot be regarded as a reliable indication of the extent of the infection. Moreover, it is useless to compare the figures with those published in previous years. The total number of notifications received during the year 1916 is 1,499, and the total number of deaths 666. Apparently the deaths are those which took place in the districts in which the disease is notifiable. The figures appertaining to the City of Sydney offer material for comparison with previous years. The number of cases notified in the City of Sydney in 1916 is 233. In the year 1904, when the disease was first notified, the number was 146. In the two following years it sank to 128 and 118. In the year 1910 it exceeded 200 for the first time, and in 1914 it reached within 7 of 300.

A proposal is put forward for the institution of a central bureau, where all patients could receive proper classification. Medical reports would be provided at the bureau. The persons suffering from advanced disease would be sent to suitable institutions, while those with early lesions would be admitted to sanatoria. Before this scheme is carried into effect, it is stated that additional accommodation for an extra 100 patients is to be provided at the Waterfall Sanatorium, and that a hospital for 300 patients in advanced stages of tuberculosis is to be established at Little Bay. The Director-General urges that four weapons should be used for fighting tuberculosis. They are the education of the public in regard to the dangers of the disease, the compulsory notification and registration of all cases of tuberculosis, the provision of sanatoria for the treatment of early cases, and, lastly, the segregation of advanced cases in special hospitals. These measures have frequently been recommended, and in some places they have been carried into effect. Something similar forms the basis of Sir Robert Philip's Edinburgh scheme. The success of a campaign based in these principles depends on the manner in which the control is carried out. Teaching the public that tuberculosis is a highly infectious disease, and that the person who comes in contact with a consumptive necessarily runs a grave risk, may do more harm than good. It is difficult to make the non-medical person understand that the infectivity of tuberculosis is a very different thing to that of measles or diphtheria, and that the danger to others lies more in the accumulation of infective material than in the direct introduction of bacilli. A close association with a person suffering from tubercular disease may be unattended by risk, if the sputum and other infected material is properly dealt with, and if attention is paid to the general health of the individual. On the other hand, grave danger of ultimate infection must exist when the environment of the patient is constantly being loaded with bacilli, and when the resistance of those in contact with him is lowered by unhygienic surroundings, improper feeding, alcoholism, want of exercise in the open air and debility resulting from other infections. As a rule, the public either refuse to believe in the danger from infection altogether, or else are so terrified at the prospect of becoming victims of the disease that their utility as members of a household and of a community is seriously affected. The exaggerated doctrines spread by various well-meaning societies and groups of people in connexion with the control of tuberculosis are certainly not beneficial to the public generally.

The Waterfall State Sanatorium.—In a separate portion of the report the Medical Superintendent, Dr. H. W. Palmer, of the Waterfall State Sanatorium, gives an account of the work carried out during the year. On the last day of 1915 there were 346 patients in the institution. During the twelve months 505 patients were admitted. At the end of the year 339 persons were still under treatment. The number of patients discharged during the year was 356. Of these, 83 left the institution with their disease arrested, and 91 left much improved in health and able to undertake a moderate amount of work. We regret that the Medical Superintendent does not classify his patients according to the stage of their disease. It is, however, apparent from his report that the number of those admitted in the third stage of the disease is about twice that of those admitted during the first or second stage. Notwithstanding this highly unfavourable basis for work, some improvement was obtained in 137 other patients, and only 45 left the Sanatorium unimproved. The deaths numbered 156. The average length of stay of the total number of patients in whom the treatment was completed was 217 days. It averaged 309 days among those whose disease was arrested, 272 days among those who were much improved, 259 days among those who died, and 123 days among those who were improved. In the case of the 91 patients discharged unimproved, while the average stay was 87 days, over 45 did not remain in the institution for a fortnight. The treatment adopted was on the usual lines, and included tuberculin in suitable cases. An amply justified complaint is made that the utility of the Sanatorium is being seriously interfered with by the admission of persons who should be taken care of elsewhere. It is not only useless to send persons with advanced pulmonary tuberculosis to a sanatorium; it is actually harmful to those whose disease may become arrested under favourable conditions. From an economical point of view, it is wasteful to house persons in the advanced stages of tuberculosis in a sanatorium where the cost per bed works out at £53 16s. 2d. The establishment of a central bureau would lead to a proper classification of cases and to the selection of patients for sanatorium treatment whose disease may be amenable to climatic, hygienic and dietetic influences.

Venereal Diseases.

The Director-General refers to the fact that a Select Committee had been appointed to enquire into the best method of combating venereal disease. He also devotes a paragraph to the question of notification. After pointing out that the members of the Royal Commission on Venereal Diseases unanimously decided not to recommend any system of notification, he states that the chief reason urged in favour of notification is that, as it has proved of value in other infective processes, it should be extended to these diseases. This view will not meet with universal endorsement. The chief argument in favour of the introduction of notification of venereal diseases with which we are acquainted is that, since the only possibility of control lies in the adequate treatment of every infected person, and since a large proportion of persons suffering in this way are not disposed to submit themselves voluntarily to treatment, the public health authority would thus have a record of every infected person, and consequently means could be adopted to enforce treatment. The argument which the Director-General adduces against the introduction of this measure is that venereal disease does not demand the isolation of patients, and does not necessitate the disinfection of premises. Isolation of persons suffering from an infective process is but one step in the prophylaxis. It is not even the most important. Isolation of consumptives is unnecessary, if means are taken to teach them how to dispose of their sputum and other discharges. The detection of the source of infection and the enforced control of that source are equally important steps in prophylaxis, and are just as necessary in venereal diseases as in other infective processes. There is a reasonable doubt whether the disinfection of premises is an expedient of value in the prophylaxis of such diseases as diphtheria.

The Director-General voices the opinion that the most effective method of dealing with these diseases would be by obtaining the co-operation of public hospitals throughout the State. He believes that the difficulty is not in inducing persons suffering from these diseases to submit themselves to treatment, but in securing the co-operation of hospitals, and provision of funds for the establishment of clinics. The experience in other States and in other parts of the world does not confirm this opinion. He speaks of negotiations which were proceeding with the authorities at the Sydney Hospital to establish a clinic on the lines of the one that had proved so successful at the Royal Prince Alfred Hospital.

Leprosy.

During the course of the year 1916 five persons were admitted to the Leper Lazaret after it had been established that they were suffering from leprosy. The clinical histories of the patients are given in a special report of the Medical Superintendent of the Coast Hospital. The total number of patients in the Lazaret on the first day of the year was 22, making 27 together with the five new patients. One death occurred. The patient, a Chinaman, aged 48 years, had been under treatment for three weeks only. One patient was discharged after having been in the Lazaret for nearly four years. He had been treated with oil of chaulmoogra and strychnine. There were no signs of active disease at the time of discharge. Since the detention of lepers was first provided for there have been no less than 142 patients in the Lazaret.

(To be continued.)

Vital Statistics.

GREATER SYDNEY.

The Government Statistician of New South Wales has issued his annual statement concerning the vital statistics of the Metropolitan Combined Sanitary Districts for the year 1917. These districts include the city of Sydney, 40 suburban municipalities and Kuring-gai Shire under the term Metropolis, and 11 municipalities, together with Waringah and Hornsby Shires under the term Outer Metropolitan Districts.

The population of the Metropolis was estimated, on December 31, 1917, at 777,300. This figure represents an increase of 12,700 for the year. The population of the city has remained stationary at 106,000.

During the year 1917, 7,009 marriages took place. This represents a marriage-rate of 9.09 per 1,000 of population. The rate is the lowest since 1899, and is 28.5% below the average for the previous five years. The number of males under 21 years of age who married was 238, or 3.4% of the total, and of females 1,075, or 15.3% of the total.

The number of infants born in the metropolis was 20,278. Of these, 10,348 were males and 9,930 were females. The proportion of males to females was 104 to 100. The birth-rate for the year was 26.3 per 1,000 of population. This is 7% below the average for the preceding five years and is the lowest since 1909. The illegitimate birth-rate works out at 1.79 per 1,000 of population. No less than 60% of the illegitimate infants were born in public institutions.

The number of deaths recorded during the year was 7,518. In 4,133 cases the death was of males and in 3,385 it was of females. The death-rate is given at 9.75 per 1,000 of population. This death-rate is the lowest on record, and is 10.1% below the average for the last quinquennial period. The infantile mortality rate is also the lowest on record; it is 59.8 per 1,000 births. The death of persons aged 65 or over represents 30.5% of the total number of deaths. There were 11 deaths of persons over 95, of which two took place at the age of 100 and 102 respectively. An interesting chart is appended, giving the curves of the infantile mortality rate, birth-rate and the marriage-rate for the metropolis, from the year 1893. The most striking change during this period is shown in the infantile death-rate. Between 1893 and 1898 the rate varied within the limits of 130 to 155 per 1,000 births. From 1898 there has been a fairly consistent fall of five deaths per 1,000 births each year. On the other hand, the marriage-rate has tended to increase more or less regularly from 1893 to 1912. A high level was maintained until 1915. The subsequent drop has returned the rate to almost the same level as at the beginning of the period. The birth-rate was high in 1893, viz., 33.5. It underwent a sudden and considerable lowering during the following five years and then was maintained at approximately the same level until 1908. Between the years 1908 and 1912 the birth-rate, like the marriage-rate, rose steadily. It was, however, not maintained, and is now tending towards the same low level as obtained between the years 1897 and 1908. The general death-rate has shown a few irregularities, which are also reflected in the infantile mortality rate. There has been a general tendency downwards and the gain is still being continued. In 1893 the death-rate was 15.5 and in 1917 it was 9.75.

In the Outer Metropolitan Districts, the estimated population was 84,430. The marriage-rate was 6.44 per 1,000 of population, which is 17% below the average for the previous five years. The number of births registered was 2,379, which is equal to a birth-rate of 30.64 per 1,000. This rate is slightly above the average for the last five years. The illegitimate birth-rate was 0.77 per 1,000 of population, a figure considerably lower than the average. The number of deaths registered in 1917 was 670, and the death-rate was therefore 8.63 per 1,000 of population. This figure is 11% below the average death-rate of the previous five years. The infantile mortality rate was 43.7 per 1,000 births, representing the lowest rate on record. These figures, however, are all exclusive of the large benevolent homes and mental hospitals. The death-rate in these institutions is extremely heavy. It is given as 178.72 per 1,000 of inmates in residence at any given time.

The figures given for the Metropolitan Combined Sanitary Districts apparently include the individuals in the benevolent homes and mental hospitals. The marriage-rate was 8.79 per 1,000 of population, the birth-rate was 26.52, the illegitimate birth-rate was 1.69, and the death-rate was 10.82 per 1,000 of population. The infantile death-rate was 58.1 per 1,000 births.

A considerable amount of varied information is contained in a series of tables dealing with the main statistical returns. Of the 7,009 marriages, 3,193 were solemnized in the Church of England, 1,400 in the Roman Catholic Church, 823 in the Presbyterian Church and 740 in the Methodist Church. Only 318 were contracted at the Registry offices. Of the contracting parties, 35 (14 males and 21 females) were illiterate. In 5,941 cases both contracting parties were previously unmarried. There were 356 widowers and 94 divorced males who married spinsters. The number of bachelors who married widows was 305, of widowers who married widows 147 and of divorced males who married widows 18. In the case of divorced women, the husband was a bachelor in 112 cases, was a widower in 23 cases and was divorced in 13 cases.

The causes of death are given in greater detail for the Metropolitan District than for the Outer Metropolitan Districts or for the Combined Districts. The following information, however, is culled exclusively from the larger area of Metropolitan Combined Sanitary Districts. The total number of deaths from diseases of the cardio-vascular system aggregated 1,920, including 1,231 from organic diseases of the heart, 327 from cerebral hæmorrhage, 152 from diseases of the arteries and 56 from acute endocarditis. There were 548 deaths from Bright's disease, 26 from alcoholism and five from chronic lead poisoning. Of the infective processes, tuberculosis caused 603 deaths, including 485 from pulmonary consumption. Diarrhœa and enteritis killed 515 persons, of whom 379 were under two years of age. There were 318 deaths from pneumonia and 180 from broncho-pneumonia. The number of deaths from diphtheria was 95, from pertussis 49, from syphilis 47, from epidemic cerebro-spinal meningitis 39, from simple meningitis 37, from enteric fever 33, from influenza 28, from morbilli and from erysipelas 15 each, from septicæmia 15, from tetanus 13, from scarlatina 11, from malaria 5, from dysentery 3, from beri-beri 2, from mycosis 2, and from leprosy and pellagra one each. In addition, two deaths were ascribed to gonococcal infections. The number of deaths from cancer was 910. Diabetes ended fatally 138 times, while chronic bronchitis accounted for 183 deaths and acute nephritis for 39. There were 145 deaths from pathological conditions associated with pregnancy and the puerperal state. Of these 42 are entered under the rubric of puerperal septicæmia, 27 under the rubric of albuminuria and convulsions, 12 as instances of *phlegmasia alba dolens*, and 19 as the results of illegal operations.

Special Correspondence.

(By Our Special Correspondent.)

LONDON LETTER.

New Army Medical Advisory Board.

The Secretary of the War Office announced early in April, 1918, that the Medical Advisory Board had been reconstituted as follows, on the expiration of the term of service of the former members:—

President: Lieutenant-General T. H. J. C. Goodwin, C.B., C.M.G., D.S.O.

Members: Major-General Sir B. E. Dawson, G.C.V.O., C.B.; Major-General Sir B. G. A. Moynihan, C.B., F.R.C.S.; Colonel W. H. Horrocks, C.B.; Colonel Sir R. Jones, C.B., F.R.C.S.; Lieutenant-Colonel Sir H. J. Stiles.

Secretary: Mr. E. T. Gann.

The Board has been reduced in size, and, apart from Lieutenant-General Goodwin, Director-General of the Army Medical Services, the only member of the old Board is Colonel Horrocks, expert in sanitation, while Mr. E. T. Gann retains the post of Secretary. The retiring members are Colonel Sir W. B. Leishman, Major-General Sir A. A. Bowlby, Major-General Sir J. R. Bradford, Sir C. A. Cameron,

Professor L. E. Hill, F.R.S., Professor H. R. Kenwood, C.M.G., Major-General G. M. Harper, Brigadier-General E. H. Hemming, and Surgeon-General Sir R. H. Charles.

Of the new members, Sir Bertrand Dawson is Physician to the London Hospital and Consulting-Physician to King Edward's Sanatorium, Midhurst, and King George's Hospital. During the war he has been in command of the No. 2 London General Hospital. Sir B. G. A. Moynihan, who is Professor of Clinical Surgery at Leeds University, has been on special service with the Army Medical Corps of the United States of America. Sir Robert Jones, Director-General of Military Orthopædic Surgery for the British Isles, has been of great service to the military authorities since the outbreak of war. Sir H. J. Stiles was Surgeon to the Royal Edinburgh Hospital for Sick Children and to the Chalmers Hospital, Edinburgh.

Rhodes Scholars.

In their annual report, the Rhodes Trustees for 1916-1917 state that the war has interfered increasingly with the operation of the scholarship system. At the close of 1916 the American section of the scholarships was still barely affected; but, on the entry of the United States into the war, the difference between American and colonial Rhodes scholars naturally ceased to exist. The Trustees have decided to postpone for the present all further elections to scholarships. This will not, however, interfere with the holding of the annual qualifying examination in the United States or in colonies where qualification is not obtained through affiliation of local universities with the University of Oxford.

The Trustees have continued their policy of giving scholars leave of absence for the duration of the war, with the right to resume or commence their scholarships when the war is over, or earlier should circumstances make that possible. For 1916 57 scholars were elected, 25 colonials and 32 Americans. Of these, there came into residence in October, 1916, three colonials and 27 Americans. Altogether, there were in residence in Oxford for some part of the year 85 Rhodes scholars, of whom 71 were American and 14 colonial. Of the 71 Americans, the great majority are now serving in the United States Army.

For 1917-1918 there are at present eight Rhodes scholars in residence—six colonial and two American. Of the six colonials, five are medical students; and of these five, two have already seen service. Of the two Americans, one has returned from a year's ambulance work on the French front, and is temporarily engaged in Government work in the University Chemical Laboratory, while the other has been rejected, on medical grounds, for military service. In addition, one ex-scholar has returned after three years' military service in France, to complete his medical course.

The scholarships set free under the Act of Parliament cancelling the German Rhodes Scholarships have been allotted as follows: One to the Transvaal; one to the Orange Free State; one to Alberta and Saskatchewan; and one to Kimberley and Port Elizabeth alternately.

Fourteen scholars and ex-scholars have given their lives in the service of the Empire during the year, and the following military honours have been won: One bar to the Military Cross; eighteen Military Crosses; one Distinguished Conduct Medal; and two *Croix de Guerre*.

The various honour examinations, including the B.C.L., give the following results: First classes, three; second classes, eleven; third classes, three; fourth classes, one.

Five scholars were admitted in the year to read for advanced degrees.

The Future of the Population.

Mr. T. E. Sedgwick delivered a very illuminating lecture on March 27, 1918, before the Royal Colonial Institute at Caxton Hall on "The Imperial Population After the War."

The proposals enunciated by the lecturer had for their intention to make the Empire as a whole self-supporting; to maintain the present improved standards of wages and of living after the war; to abolish workhouses and increase old-age pensions; to increase manufactured exports by multiplying overseas customers, by developing emigration and production within the Empire; to facilitate the investment of British capital within the Empire; to settle the unpeopled lands of the dominions and reduce the pressure of competition at home; to reduce the number to be fed at home, whilst increasing the Empire's food production; to ensure employment for partially disabled soldiers and sailors, and generally to reduce the labour unrest which would otherwise be inevitable after the war. He argued that migration was not emigration, as the migrants would still be citizens of the same nationality if the stream of migration was directed to the dominions instead of to foreign countries. That kind of migration was a most productive investment. Canada, for instance, doubled her population in forty-five years by the expenditure of only £3,000,000. After the war Great Britain would have a bigger population, both working and actual, than if there had been no war. Even if we lost half a million men in the war, the loss would have been more than made good in the old country by other causes. Against our losses we had to set 500,000 "saved" to this country by the check of migration; the 380,000 Belgians settled here, many of whom would remain; and the 20,000 additional Chinese, Japanese, West Indians, Americans and others now taking the jobs of those fighting, this total representing an actual increase of civil population of 900,000, as an offset to a possible loss of 500,000 by the war.

Our home increase in population before the war was 1,000,000 net every three years, even after allowing for the net emigration of upwards of 250,000, and there was every reason to believe that the boom in marriages, infant life-saving crusades, and the improved standards of living for the workers would keep up our survival rates. The problem of an over-crowded Britain would therefore be greater after the war than ever, and migration on a larger scale than ever would be necessary, as it was in the year after the South African war, when the return of 250,000 men from South Africa was followed by the emigration of 217,000 persons from Great Britain for the United States alone. The lecturer's contention was that Great Britain would benefit by the migration of its surplus population, while the Empire as a whole would be the gainer, provided that migration was directed to our own dominions instead of being allowed to go to foreign lands.

Correspondence.

NURSES AND RADIOGRAPHY.

Sir,—It appears to me that the suggestion put forth by Dr. Herschel Harris is in danger of being turned down, because of the opposition of the X-ray specialists.

I take it that all that was meant was that if certain nurses showed that they have sufficient intelligence they should be selected, in the large city hospitals, to receive instruction in X-ray work, and if any of these nurses were selected for country hospitals, that they would prove a God-send to that particular institution, if found competent to take X-ray pictures of fractures or of bismuth meals. The interpretation of the plates rests with the medical man; in the simple cases he who runs may read; in the difficult cases, well, if they are difficult with the X-ray plate before you, how much more difficult will they be without it!

Not a month passes but a case comes from the country, when one can see how much the country practitioner would have been helped if he had had the benefit of an X-ray plate. Why then put obstacles in his way, if his difficulties can be overcome by a little more knowledge imparted by and to a nurse? If an X-ray specialist is in danger from a nurse setting up in opposition to him, then his reputation is such that it does not need an X-ray to fathom it.

Yours, etc.,

STEWART McKAY.

227 Macquarie Street, Sydney,
August 9, 1918.

The undermentioned has been nominated for election as a member of the New South Wales Branch of the British Medical Association:—

William Angwin Edwards, M.B., Ch.M., 1914 (Univ. Sydney), "Craignish," Macquarie Street, Sydney.

Proceedings of the Australian Medical Boards.

QUEENSLAND.

The following have been registered, under the provisions of *The Medical Act of 1867* as duly qualified medical practitioners:—

Daly, Terence Aubrey, Rockhampton, M.B., Ch.M., Univ. Syd., 1914.

de Pinna, Herbert Alfred, Cunnamulla, M.R.C.S., Eng., L.R.C.P., Lond., 1905.

Additional Registration:—

Young Wai, Joshua, Surat, Ch.M., Univ. Syd., 1918.

Medical Appointments.

Dr. A. Macdonald (B.M.A.) has been appointed Officer of Health of the Borough of Sale, Dr. W. H. F. Rail (B.M.A.) for the Quambatook district of the Shire of Kerang, and Dr. R. E. Dunn for the North and West Ridings of the Shire of Stawell, Victoria.

Dr. E. C. Williams (B.M.A.) has been appointed Acting Government Medical Officer at Mackay and Visiting Surgeon to His Majesty's Police Gaol, Mackay, Queensland, during the absence of Dr. H. W. Lording (B.M.A.).

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xv.

In future, no advertisements inviting applications from medical practitioners for positions in public institutions will be accepted unless the appointment is limited to medical practitioners who are ineligible for military service, or who have returned from military service. The term "ineligible for military service" is used to signify practitioners who are above military age, those who have offered their services and have not been accepted by the military authorities, or those who, for valid reasons, are incapable of applying for a commission in the Australian Army Medical Corps.

Queenstown Hospital Union, Tasmania, Second Medical Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	All Friendly Society Lodges, Institutes, Medical Dispensaries and other contract practice. Australian Prudential Association Proprietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United Friendly Society Institute. Townsville Friendly Societies' Medical Union. Cloncurry Hospital.
SOUTH AUSTRALIA. (Hon. Sec., 8 North Terrace, Adelaide.)	Contract Practice Appointments in South Australia. Contract Practice, Appointments at Renmark.
WESTERN AUSTRALIA. (Hon. Sec., Health Department, Perth.)	All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Parramatta, Auburn and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
TASMANIA. (Hon. Sec., Macquarie Street, Hobart.)	Medical Officers in all State-aided Hospitals in Tasmania.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, N.Z.

Diary for the Month.

Aug. 20.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Aug. 21.—W. Aust. Branch, B.M.A.
Aug. 23.—Q. Branch, B.M.A., Council.
Aug. 27.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Aug. 28.—Vic. Branch, B.M.A., Council.
Aug. 29.—S. Aust. Branch, B.M.A.
Aug. 30.—N.S.W. Branch, B.M.A.
Sept. 4.—Vic. Branch, B.M.A.
Sept. 6.—Q. Branch, B.M.A.
Sept. 10.—Tas. Branch, B.M.A., Council and Branch.
Sept. 10.—N.S.W. Branch, B.M.A., Ethics Committee.
Sept. 12.—Vic. Branch, B.M.A., Council.
Sept. 12.—Last Day for Nomination of Two Candidates for Federal Commitee.
Sept. 13.—S. Aust. Branch, B.M.A., Council.
Sept. 13.—N.S.W. Branch, B.M.A., Clinical.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.

The Honorary Librarian of the New South Wales Branch of the British Medical Association is anxious to complete the series of the *Lancet* at present in the Library of the Branch. The issues of January 4 and 25, March 14 and August 15, 1908, and January 9, 1909, are needed for this purpose. The Librarian will be grateful if any member who is able to present to the Library one or more of these numbers, will communicate with the Honorary Secretary of the Branch, Dr. R. H. Todd, B.M.A. Building, 30-34 Elizabeth Street, Sydney.